CHILD DEATH & SERIOUS INJURY
REVIEW COMMITTEE

Annual Report 2015–2016

Government
of South Australia

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Letter of Transmission

Hon Susan Close MP
Minister for Education and Child Development

Dear Minister

I submit to you for presentation to Parliament, the 2015-16 Annual Report of the South Australian Child Death and Serious Injury Review Committee which has been prepared pursuant to Part 7C of the *Children's Protection Act 1993*.

This report highlights the Committee's activities in fulfilling its statutory obligations.

In compliance with the *Public Sector Act 2009* and the *Public Finance and Audit Act 1987*, a further report concerning the management of human resources and financial issues of the Committee has been submitted as part of the Annual Report of the Department for Education and Child Development 2015-16.

Yours faithfully

Dymphna Eszenyi

Chair
Child Death and Serious Injury Review Committee

31 October 2016

Chair's Foreword

I am pleased to present the Committee's eleventh Annual Report to Parliament under Part 7C of the *Children's Protection Act 1993.*

The reviews of all deaths of children who have died in South Australia, both during the 2015 calendar year and cumulatively since the Committee's work began, continue to point to opportunities to change and improve systems.

The relatively high death rates of Aboriginal children suggest that a concentration of effort might produce life-saving results in that population. Of particular and ongoing importance are the statistics showing the very high death rate in the Aboriginal population arising from conditions originating in the perinatal period. Systemic work to ensure healthy pregnancies has resulted in relatively low death rates in non-Aboriginal populations. The Committee looks forward to seeing better programs across all domains of maternal and child health to reduce the early deaths of Aboriginal infants.

The Committee has continuing concerns that children under the Guardianship of the Minister, and their children, are at relatively high risk of death and serious injury. This is a small but vulnerable group of young persons and their children. Given that this group is so clearly identified in our reviews, it is an obvious focus for heightened assistance by all systems with responsibility for providing services to it.

In monitoring action in response to its recommendations, and its less formal suggestions, the Committee has been pleased with the actions undertaken by some agencies. Housing SA has undertaken a 'whole of agency' development of its ability to focus on and support the needs of children. SA Health continues to work on system improvement. There have been some promising developments of new systems within the education department to help schools respond to the needs of children who are not adequately engaged with schooling.

It is clear to the Committee, however, that Families SA's systems are still underpowered for the task of knowing or keeping a record of enough about the circumstances of children coming into, or already under State care, to provide effective support for them. In the Committee's view these systems require urgent improvement.

Six members - Alwin Chong, Lynne Cowan, Michelle Hasani, Barry Jennings, Nicole Stasiak and Trish Strachan - have completed their service to the Committee's work. Their contributions were of great benefit to the Committee and its secretariat. The

recommendations they crafted have the potential to be of great benefit to children in this State.

On behalf of the Committee I extend my condolences to the families and friends who have experienced the death of a child and to the communities and professionals who cared for them.

I commend this report to you, and encourage all those who seek to care for children and keep them safe, to read it. I share the Committee's hope that the report will be of assistance in guiding your efforts to keep children safe and well.

DJ Eszenyi
Chair

Child Death and Serious Injury Review Committee

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ABS	Australian Bureau of Statistics
Act	*Children's Protection Act 1993*
AHPRA	Australian Health Practitioners' Regulatory Agency
AIHW	Australian Institute of Health and Welfare
ARIA+	Index of Remoteness and Accessibility, Australia
ATSI	Aboriginal and Torres Strait islander
CaFHS	Child and Family Health Service
CDSIRC	Child Death and Serious Injury Review Committee
Children	In this report 'children' includes infants, children and young people from birth up to 18 years
DECD	Department of Education and Child Development
ICD–10	International Classification of Disease (Version 10)
IMR	Infant Mortality Rate
Infant	A child less than one year of age
IRSD	Index of Relative Socio-economic Disadvantage
MECD	Minister for Education and Child Development
NDIA	National Disability Insurance Agency
SEIFA IRSD	Socio-Economic Indexes for Areas, Index of Relative Socio-economic Disadvantage (IRSD)
SIDS	Sudden Infant Death Syndrome
SUDI	Sudden Unexpected Death in Infancy
UCV	Universal Contact Visit
WCHN	Women's and Children's Health Network

Acknowledgements

The Committee wishes to thank the following individuals and organisations for making themselves available to support the Committee's work:

- Australian and New Zealand Child Death Review and Prevention Group (ANZCDR&PG) representatives attending ANZCDR&PG meetings who share insights gained from their own jurisdictions
- Department for Communities and Social Inclusion which continues to provide technical advice and support for the Committee's database, and assistance with records management
- Department for Education and Child Development for its support with administrative, financial and human resource management
- Department of Education and Child Development, Data Management and Information Systems, Edward Trojanowski, Demographer
- Kidsafe SA
- National Centre for Health Information Research and Training, Brisbane, especially Ms Sue Walker, Director
- Office of Births, Deaths and Marriages
- SA Health Epidemiology, Systems Performance Division
- SA Health, Health Statistics Unit, Kamalesh Venugopal, Unit Head
- SA Health Maternal and Perinatal Mortality Committee
- State Coroner, especially Mr Mark Johns, Coroner and staff
- Women's and Children's Health Network Records Management team
- Chief Executives and Senior Officers from the Department of Education and Child Development, the Department for Communities and Social Inclusion, SA Health and SA Police for contributing to the Committee's understanding of service delivery in their departments.

Committee Members

Chair

Ms Dymphna (Deej) Eszenyi

Members

Mr Alwin Chong	until 30 June 2016
Ms Lynne Cowan	until 30 June 2016
Ms Angela Davis	
Dr Mark Fuller	
Ms Dianne Gursansky	
Ms Michelle Hasani	until 30 June 2016
Mr Barry Jennings QC	until 30 June 2016
Dr Deepa Jeyaseelan	
Dr Margaret Kyrkou OAM	
Mr Tom Osborn APM	
Ms Nicole Stasiak	until 30 June 2016
Dr Nigel Stewart	
Ms Trish Strachan	until 29 April 2016
Ms Barbara Tiffin	

Executive Summary

This is the eleventh Annual Report of the Child Death and Serious Injury Review Committee.

Purpose and establishment

The Committee contributes to efforts to prevent death or serious injury to children in South Australia. It was established by the *Children's Protection Act 1993* (the Act) in February 2006.

The Committee reviews the circumstances and causes of death and serious injury to children. It makes recommendations to Government for changes to legislation, policies and procedures that may help prevent similar deaths or serious injuries.

Reviews and recommendations

In 2015-16, the Committee's reviews have focussed on the following:

- The cases of three children who died or were seriously injured as a result of ***neglect and cumulative harm*** are reviewed in Section 1 of this Report. The reviews show that services did not adequately recognise their extreme vulnerability, nor commit to protecting them, nor preventing further harm.
- Families SA has not been able to provide statistical information requested by the Committee about the services provided to ***Children under the Guardianship of the Minister.*** This information was requested after submitting a review in 2015 about infants who died and whose parents had a history of guardianship. Without such information it is hard to determine whether these children are receiving the care and protection they need.
- The Committee has reviewed 32 of the 39 deaths of children attributable to ***suicide*** during the period 2005-15. The Committee has made recommendations for a range of prevention strategies, including the importance of appropriately planned and delivered mental health services to children and young people.
- The cause of death of most infants whose families had contact with Families SA was illness or disease. Improved outcomes for ***vulnerable infants*** rely on the

development of effective working relationships between the health and child protection systems.

- Two hundred and sixty-six children of the 1215 children who died between 2005-15 (22%) had a ***disability that impacted their daily living.*** The Committee continues to hold concerns about its access to information about these very vulnerable children, including: the number who have received prompt paediatric assessments; the process and timeframe for the provision of a child's medical history to their carers; and the ways in which the NDIS will manage the delivery of services to children who live in vulnerable families.
- More can be done to develop interventions that provide practical support to enable families to provide ***safe sleeping places for their infant.*** The Committee is of the view that particular attention must be given to those families whose lives are relatively chaotic, and where parenting capacity is compromised by such factors as financial constraint, housing insecurity, and alcohol and drug use.

Statistical patterns and trends

Over eleven years, the rate of child death in South Australia has shown a significant reduction. The overall death rate is 31.3 deaths per 100 000 children for the period 2005-15.

Death rates that show a decrease include:

- Transport incidents. The death rate is 3.2 transport deaths per 100 000 children. When only the deaths of 15-17 year olds attributed to transport incidents are considered, the death rate shows an 11% decrease, on average, per year.
- The Infant Mortality Rate declined by 3% per year in the period 2005-15.

Outcomes for the State's most vulnerable children

- ***Aboriginal children*** are 3.6 times more likely to die than non-Aboriginal children. The death rate for the period 2005-15 is 105.5 deaths per 100 000 Aboriginal children. This rate is not declining.
- Children who lived in the State's ***most disadvantaged areas*** had a higher death rate than those who lived in the State's least disadvantaged areas. The

death rate for children living in the most disadvantaged areas of the State is not declining.

- The death rate for all ***infants who died suddenly and unexpectedly*** has declined, but the rate for infants living in the State's most disadvantaged areas has not changed.
- The death rate for ***children with disability*** is not showing any change.

Future directions

The statutory responsibility of the Committee is to review cases of child death and serious injury with a view to identifying systemic change that may prevent future deaths or serious injury and to make and monitor the implementation of its recommendations.

To fulfil these obligations in 2016-17 the Committee will:

- Monitor service delivery to children who have been under the Guardianship of the Minister and monitor the deaths of infants whose parents were under guardianship.
- Review and make recommendations about the care of children with a disability who died whilst under the guardianship of the Minister.
- Seek further evidence from health, education, housing and children protection agencies about progress with implementation of recommendations concerning their recognition of, and response to, the neglect of children.
- Submit reviews to the Minister that address policy and practice change in Families SA.
- Through its activities, seek evidence of better outcomes for children in light of the recommendations arising from the Royal Commission into Child Protection Systems.

Section One

Improving the safety and wellbeing of South Australia's children

S52S – Functions of the Committee

(1) The Committee's principal functions are –

(a) to review cases in which children die or suffer serious injury with a view to identifying legislative or administrative means of preventing similar cases of death or serious injury in the future; and

(b) to make, and monitor the implementation of, recommendations for avoiding preventable death or serious injury.

Children's Protection Act, 1993

1. Improving the safety and wellbeing of South Australia's children

The Committee's intent is to improve the safety of children in South Australia. It does this by collecting information about the circumstances and causes of all child deaths in South Australia, reviewing and analysing this information, making recommendations to Government and monitoring the implementation of those recommendations. From time to time, the Committee also reviews specific cases of serious injury.

In the 2015-16 year, the Committee focused its review and monitoring activities on the following issues, based on the Future Directions set out in the 2014-15 Annual Report:

- neglect and cumulative harm
- children under the Guardianship of the Minister
- suicide
- vulnerable infants
- children with complex health problems
- children with disability
- infant safe sleeping
- child safety – accident prevention.

The Committee has made and monitored recommendations about:

- legislative means of protecting children
- the actions of government agencies, both individually and as coordinated systems
- the actions of non-government agencies, private practitioners and others.

1.1. Neglect and cumulative harm

Protecting children from neglect and cumulative harm requires all agencies to recognise the impact that neglect and cumulative harm have on children, accept a role in preventing such harm, and act on the policies and procedures that reflect their commitment to prevention, ie, recognise, commit, prevent.

The reviews of the deaths of three children illustrating issues of neglect and cumulative harm were submitted to the Minister for Education and Child Development in 2015-16.

1.1.1. Review 1 (Case 888)[1]

This child died from severe injuries. Her short life was characterised by chronic neglect and exposure to risk of harm, until the final period of physical and emotional abuse she experienced in the days preceding death. In the hours before her death, her mother and her mother's partner did not seek help for her until she was unconscious and unable to be revived. The Committee attributed this child's death to neglect based on this lack of action to secure the medical attention the child needed to sustain life.

The child's mother and her mother's partner were sentenced to eight and seven years imprisonment respectively, for manslaughter by criminal neglect.

Each of the eleven recommendations made by the Committee addressed an element of practice within Families SA. Similar recommendations had been made in previous reviews, within the last five years. The Committee questioned whether Families SA had a genuine commitment to practice improvement in such fundamental areas as training staff in the development of comprehensive case plans, and to providing appropriate professional supervision for its workers.

Based on this review, and another review undertaken in 2010, both of which involved the 'Safe Families Safe Babies' program, the Committee concluded that Families SA should not provide intensive therapeutic services, and recommended that such services be delivered independently of the child protection service.

It further recommended that Families SA adopt a practice of multi-disciplinary critical appraisal of cases that have been open and active for 12 months.

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[1] *This child's death was also reviewed by the State Coroner*

Table 1: Case 888 recommendations

1. All workers who are delivering any services that involve the safety and wellbeing of infants must have the knowledge, skills and experience commensurate with the effective delivery of that service.
2. Intensive therapeutic services must be delivered independently of **Families SA.**

   Delivery of therapeutic services should include the use of explicit protocols regarding the extent of information exchange between Families SA and the therapeutic service.

   There should be an evaluation of that service measuring the risk for the child and markers of 'success' for the family, including time frames and possible outcomes for the child of success or otherwise of the intervention.
3. Child protection workers must have adequate training in the development of comprehensive case plans, including assessment and case management of families where parents have problematic alcohol and drug use, mental health or domestic violence problems.
4. The ongoing safety and wellbeing of the child must be the focus of any intervention and at the centre of all decision making. It must be embedded into service provision at all levels.
5. **Families SA,** in its social work practice with children at risk must:
   - Provide competent and supportive case supervision,
   - Provide case management (as opposed to management of incidents),
   - For each child have a plan, a strategy and a means of evaluating progress towards the safety of the child.
6. **Families SA** should adopt a practice of critical appraisal for cases that have been open and active for 12 months. Such cases should be subject to review by a multi-disciplinary team or at a minimum an appropriately qualified, non-social-work professional from outside the organisation.

   In the case of very young infants, a six month time frame may be more appropriate.
7. **Families SA** must identify complexity of cases as a determinant of comprehensive assessment.

   The management of complex cases needs to be underpinned by best practice guidelines and be evidence-based.

   Guidelines for case practice must include consultation and monitoring by senior staff and documented case plans reflecting progressive details as assessment unfolds.

   Such cases should never be managed by students.
8. Workers must be adequately trained in development of comprehensive case plans that as a minimum require a worker to read and summarise existing information held in case files about parents and the family.
9. At the conclusion of an **Adverse Events Committee** review process, **Families SA** provide the Child Death and Serious Injury Review Committee with:
   - the recommendations that have been made
   - the ways in which they will be put into practice and
   - how their impact will be evaluated.
10. **Families SA** appoint an independent person to Chair the Adverse Events Committee.
11. If **Families SA** introduce a system of algorithm-based triaging at the point of entry into the child protection system, then the algorithm used must be of sufficient complexity and sophistication to detect circumstances that may indicate serious neglect.

1.1.2. Review 2 (Case 1068)[2]

This child's health and development were seriously affected by isolation and lack of basic necessities such as food, water and hygienic living conditions. The Committee attributed his serious injuries to neglect. In December 2014, both parents were sentenced to eight years imprisonment for endangering the life of the child.

This review identified fundamental systemic failures in the delivery of services by health, child protection and housing agencies. Each service appeared to lack the willingness and/or the capacity to respond to the child's needs. Decisions were made, and actions taken with little consideration of the short or long term impact that these decisions and actions would have on the child. He suffered profoundly as a consequence.

The Committee made six recommendations addressing basic issues in service delivery.

[2] *This child's circumstances were reviewed by the Royal Commission into Child Protection Systems. At the time of writing, the Committee did not know what conclusions or recommendations the Commission had made. On 8 August the Commission released its Report. Volume 2 included the case review of this child.*

Table 2: Case 1068 recommendations

1. **SA Health and Families SA** must review the 'Vulnerable Infants' Discharge Protocol'. It must be updated so that it is clear to both agencies:

- What criteria is being used to assess risk
- What action each agency will take when an 'Unborn child notification' is made to Families SA when one or both of the parents is or has been known to Families SA
- What action each agency will take when a notification is made to Families SA by the birth hospital just before or at discharge to ensure that the infant is safe
- That there will be a case conference between Families SA and SA health within four weeks of discharge where the short and long term involvement of each agency are determined and documented.

The Protocol must make clear that no case will be closed until both agencies have agreed and documented that the infant is safe and the parents have the capacity to care for the infant.

2. **Families SA** workers must document:

- that they have made themselves aware of the histories of the family, of children about whom notifications are made
- that they have identified those aspects of parental history that may be relevant to the safety of the child
- that they have considered whether, given their history, each of the parents has the capacity to care safely for the child
- that, in cases where parental capacity is in doubt, the parents' ability to care for the child is assessed.

3. **SA Health** must review its policies and practices about **CaFHS**'s assessment of and response to infants at risk. These policies and practices must ensure that:

- An accurate and complete account of the mother and the infant's history be provided to Families SA when a notification is made
- All information about a mother and an infant is available to each CaFHS worker and is considered before decisions are made
- When an infant has not been sighted for four weeks, CaFHS has a process for determining what risks may occur to that infant's safety and wellbeing if the case is closed
- These risks are documented and discussed with a CaFHS supervisor before the case is closed.

4. **Housing SA** workers must:

- Receive training that informs them about the signs of neglect
- Take steps to confirm if children are living in a household
- Sight those children
- Assess and determine whether they suspect on reasonable grounds that a child has been, or is being, abused and/or neglected.
- Take appropriate action should they assess that there is a risk to the safety of those children.
- Create records that clearly show there are children living in a household and any steps that have been taken to protect them from harm.

5 When **Families SA** refers a child to an **NGO** for the provision of a service:

- Families SA must share information about the history of the child and their parents so that the NGO can decide if it has the capacity and staff capabilities to provide an appropriate service.
- Families SA must assess the child's ability and needs at the time of the referral.

On the basis of this shared information, Families SA must decide if:

- The NGO program is appropriate to the needs of a child.
- The NGO has staff with the necessary expertise to provide the services required to keep a child safe from harm. This is critically important when an infant is deemed to be at risk and the case is considered to be complex.
- The NGO has the capacity to provide services regardless of staff illness, leave or absences (ie` support services should be continuous).

Families SA must maintain its obligation to keep that child safe by establishing the ways in which the NGO will be accountable to it.

The NGO must understand its reporting obligations and how they are to be met.

Families SA must maintain a case management function and set time frames for:

- Regular updates during the course of the NGO's service provision
- Notification of any failure to deliver services
- Case conferencing where progress and case closure can only occur after discussion and agreement between the **NGO** and **Families SA**.

6. **Families SA, SA Health and Housing SA** must have policies about supervision practices that make it clear to supervisors and practitioners that the safety and wellbeing of a child is the key component of decision-making about that child.

1.1.3. Review 3 (Case 601)

The death of this young person was attributed to neglect. The family concerned in this case had a number of children born within a very short period of time, all of whom had disability. The child who died developed a serious medical condition two years prior to death. The serious injury of the child's siblings, due to the neglect of their basic needs, was also the subject of this review. Both parents had intellectual disability, and after the death of this child, were found guilty of criminal neglect.

In the Committee's view, without access to early intervention at critical periods in their development, all of the children lived with a higher degree of disability than they might otherwise have experienced.

It was apparent that in the absence of consistent, timely and targeted action by the various agencies involved, the eventual outcomes for all members of this family were devastating. Agencies must respond to cases of serious long-term neglect with commitment to effective case management, an integrated service response, sustained leadership in the area of care in which they specialise, and assertive engagement with families who avoid services. Disability in childhood is a core consideration for Families SA. At no time in the 15 years of contact with this family did Families SA take the approach of assessing the parents' capacity to parent the children, especially in light of their own disabilities.

The Committee made suggestions for action rather than recommendations due to the age of the case, and will monitor the assertive and active follow up of families in like circumstances by the National Disability Insurance Agency (NDIA).

Table 3: Case 601 suggested actions

Case management

Families SA must respond to cases of serious long term neglect with leadership of a long-term integrated service response. That is, they must maintain a case management function across all services involved with the child and set time frames for:

- Regular updates during the course of service provision
- Notification of any failure to deliver services
- Pro-active engagement by Families SA to rectify aspects of service delivery that are not proving effective.

Interagency Practice

When a service refers a child with a significant history of neglect to another service the outgoing case manager must be assured that:

- The new service has the capacity and staff capabilities to provide an appropriate service.
- Detailed information and experience of delivering services to the child is shared
- A case manager in the new service is assigned from the beginning of the new service contact with a vulnerable child
- That case manager receives and uses the detailed history to inform service delivery plans.
- A detailed assessment of the child and parents needs is undertaken at the time of the referral and interpreted in the light of the received detailed history.
- If the case manager changes for any reason (including the child moving residence), responsibility is taken to prepare and pass on case management and a detailed history to the new service provider.

National Disability Insurance Scheme (NDIS)

NDIS must have pro-active and assertive engagement with management of families who actively avoid the NDIS planning process and subsequent services. Specifically NDIS must have:

- Active follow-up of families not responding to the letter of offer to meet
- Active follow-up of families who have not spent their assigned service budget

Families SA and Disability Services must provide assertive case management services to families who have a history of actively avoiding the NDIS planning process and subsequent services and who would benefit from those services.

Families SA and the care of children with disability

Families SA need to increase their skill in managing safe environments for children with a disability or whose parents have a disability by:

- Developing understanding of disability and the way in which disability can impact on the ability of parents to care for their children
- Working closely with therapists and clinicians delivering disability services
- Building the capacity of disability services to practice in such a way that children with disability are kept safe.

Parenting capacity

A comprehensive assessment of parenting capacity must be undertaken in cases where Families SA is aware that children are being neglected. This will involve Families SA taking a lead role in ensuring that all departments and services are aware of the children's circumstances.

Early intervention for disability

Ability of parents to access and reinforce therapy aimed at maximising children's development must be assessed early in the life of children with developmental delay. If an unfavourable assessment is made, there must be consideration of how reinforcement of therapy and care will be supplied to the children via another means.

Risk assessment and neglect

In circumstances of neglect, the potential for acute harm or death arising from a medical condition or disability must trigger the lead agency to consider assertive case management.

Safety

Families SA must maintain its obligation to keep a child safe by establishing if an external service it relies on to keep that child safe:

- Is appropriate to the needs of the child.
- Has staff with the necessary expertise to provide the services required to keep a child safe from harm. This is critically important in situations of high risk and complexity.
- Has the capacity to provide such services.

Families SA must establish the ways in which the service it relies on to keep a child safe will be accountable to it.

1.1.4. Common themes arising from the three 'neglect' reviews

The issues arising from the reviews of all three cases, and the recommendations made by the Committee, reflect some common themes regarding neglect and cumulative harm. Many mirror the themes and recommendations provided in the Annual Report for 2014-15, and relate to:

- The wellbeing and safety of children being the central consideration in all decisions made about them.
- The necessity of sound recruitment and training of service staff.
- Ensuring the competence of staff to undertake complex cases within sound management and supervisory structures.
- Undertaking long term, proactive case management where children are suffering neglect, or are diagnosed with medical conditions.
- Understanding relevant statutory powers, and developing appropriate policies and procedures to inform practice.
- Working collaboratively with other agencies involved with the same children and their families.

1.1.5. Monitoring the implementation of recommendations

The Committee also pursued the systemic responses to neglect and cumulative harm through its monitoring activities.

The Minister for Education and Child Development has provided responses to Reviews 1 and 2.

Review 1

The Minister advised that amendments to the *Children's Protection Act 1993* (the Act) to be made by the *Children's Protection (Implementation of Coroner's Recommendations) Amendment Bill 2015* will provide for proper consideration of the effect of chronic neglect and cumulative harm. The new provisions will ensure that notifications and episodes of neglect and abuse are not considered in isolation by decision-makers, but within an historical context.

In its reply to the Minister, the Committee noted that its critique of the Bill had already questioned whether these amendments to the Act would improve Families SA's

response to ‘episodes of neglect and abuse’. The Committee will maintain this view until information confirming improved outcomes for children can be provided.

The Minister advised that the adequate training of workers was a priority for Families SA, and that there was a focus on such training within the organisation.

Review 2

The Minister advised that, in light of the review of this case by the Child Protection Systems Royal Commission, she was not in a position to comment on the Committee’s recommendations.

In response, the Committee has asked the Minister what will happen to children in similar circumstances while the Royal Commission’s review is taking place. It has provided the Minister with a list of similar recommendations made by the Committee over the past ten years, as evidence of the opportunities the agency has had to improve its practice.

Review 3

At the time of writing, no response to the actions suggested by the Committee has been received from the Minister of Education and Child Development.

1.1.6. Monitoring progress of recommendations from previous reviews

Review of six seriously injured children

In its 2014-15 report, the Committee expressed disappointment with the Government’s responses to its recommendations from its review of six seriously injured children. That review was submitted to the Minister in 2012.

In 2015-16, the Committee met with senior executives from Housing SA, Families SA and the Department for Education and Child Development (DECD) to determine what progress had been made in implementing those recommendations.

Housing SA: This agency demonstrated the significant progress it has made in implementing new policies and practices that focus on the safety of children in Housing SA properties. All Housing SA workers now have face-to-face child safety training.

Housing SA’s policies and practices now recognise the importance of sighting children and acting on concerns about their safety.

These policies and practices require officers to identify and respond to child safety concerns, and support them to undertake this work.

Families SA: The Chief Executive, DECD[3], acknowledged that the agency had faced challenges in its efforts to progress its reform goals, and to stabilize its workforce, while responding to other key issues. These issues included: recommendations arising from the Debelle Royal Commission; the Coroner's inquiry into the death of Chloe Valentine; the increasing number of children in the out-of-home care system; and the increasingly complex issues faced by families whose children are in need of child protection services.

The Chief Executive considered that the system was 'better placed' to respond to the needs of children than it was at the time the Committee's 2012 recommendations were received. The system was moving forward with the redesign of child protection services, which included improved ways of recognising and responding to neglect and cumulative harm.

It is the Committee's view that scores of notifications, beginning when a child is very young, should be predictive enough to identify the need for timely attention.[4] The Committee viewed Families SA's revision of its assessment tools and processes as an opportunity for improved response.

The Committee met with the reviewers of the assessment tools, and subsequently provided the Minister with its views about the construction of the tools with respect to child death and also about the application of the tools if they were to effectively assess neglect and cumulative harm. Additional steps were outlined to ensure that the revision was effective.

The Chief Executive DECD, has advised that the Committee will receive information about changes to the tools or the assessment processes at the conclusion of its review.

In relation to the Committee's view that Families SA should review cases where scores of notifications have been received over a sustained period of time, the Committee has also considered the role of the Auditor General. The Committee wrote to the Auditor General asking, in part:

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[3] *At the time of this meeting, the Chief Executive, Department for Education and Child Development (Mr T Harrison) was responsible for the operations of Families SA.*
[4] *http://www.cdsirc.sa.gov.au/files/links/201415_cdsirc_annualreport.pdf*

Whether consideration may be given to a review of cases where notifications are numerous over a sustained period of time, to prevent the outcomes that bring these cases to (the Committee's) attention.

No response has been received, but the Committee notes the ways in which the Victorian Auditor-General has undertaken similar audits of the actions and activities of the Victorian child protection system.[5]

The Department for Education and Child Development: The Committee met with the Chief Executive and senior executives from DECD about the issue of chronic truancy. The Committee has pursued issues concerning the ways in which the education system monitors and responds to students who are chronically truant or absent from school.

Children's frequent absences from school is a common factor in many of the reviews undertaken by the Committee, and has been associated with the abuse and/or neglect of children. The Committee has also recommended that keeping young people engaged in education is an important way to help reduce the risk of suicide.

The Chief Executive reported that the employment of 60 Wellbeing Coordinators, and the introduction of a system that gives education staff 'real time' access to information about individual students, should improve school responses to issues of truancy and absences.

The Chief Executive said that the 'One Child One Plan' policy, should also assist with the handover of information about a child through the crucial transition points of pre-school to primary school, and primary to secondary school. The Committee will continue to request updates on the impact of these changes on chronic truancy rates, and will look for evidence in its reviews that these systems have been used to address truancy and disengagement from schooling.

1.2. Children under the Guardianship of the Minister

In the eleven years between 2005 and 2015, 19 children died while under the guardianship of the Minister.

In addition, 16 children who died in the same eleven year period had at least one parent who had previously lived under guardianship.

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[5] *Follow up of Residential Care Services for Children. Victorian Auditor-General's Report. June 2016.*

In 2015, the Committee submitted a review to the Minister about nine children who died, who had at least one parent with a history of guardianship. The Committee asked the Minister to provide information about current practices, data collection and service responses, and the outcomes for young people transitioning from guardianship to independence. It considers that this information is key to policy development and operational accountability.

In August 2015, the Minister provided information about current practices and services that could be accessed by children under guardianship. However, the report provided by the Minister stated that:

Families SA systems are not currently structured in a way that readily enables extraction of the statistical information requested by CDSIRC…

At the time of writing, 16 months after requesting this information, the data requested by the Committee has not been provided.

In the view of the Committee, a child protection system that is unable to provide this information has no way of knowing if children in care are safe and well.

1.3. Suicide

Services that have been designed specifically for children and young people and delivered by appropriately trained staff, are key to the prevention of suicide.

During the period from 2005 to 2015, 39 child deaths have been attributed to suicide. Two-thirds of the children who died were male, and eight of the 39 were Aboriginal.

The Committee has reviewed 32 of these 39 deaths using the 'life chart' methodology adapted from the work of Fortune, Stewart, Yadav and Hawton (2007).[6] The review found that thirty-eight percent of the young people who suicided had emerging mental health problems, such as depression and anxiety, in some starting several years before their deaths. In contrast, the life charts of nine young people, all males, showed a pattern of multiple and complex challenges in their lives from when they were very young, including poor early attachment and learning difficulties at school. In the years before their deaths, these young people were typically disengaged from family,

[6] *Fortune, S, Stewart, A, Yadav, K, and Hawton, K (2007), Suicide in adolescents: using life charts to understand the suicidal process. J of Aff Disorders, 100, 199-220.*

education and social supports. The life histories of a smaller group of young people suggested that they were functioning well prior to their deaths. The Committee has made recommendations in relation to prevention strategies for each of these groups.

This review of suicide is ongoing and highlights the importance of appropriately planned and delivered mental health services for children and young people in South Australia. For the past year, the Committee has requested information from SA Health about the Government's plans for the delivery of such services. At the time of writing, SA Health had offered the Committee a meeting with the Executive Director of Mental Health Strategy.

1.4. Vulnerable infants

Improvement to outcomes for vulnerable infants relies on the development of strong and effective working relationships between the health and child protection systems.

Over the eleven year period 2005-15, nearly 60 percent of child deaths were of infants under one year of age, usually from causes associated with illness and disease. The cause of death of most infants who had contact with the child protection system in the three years prior to their death was illness or disease. The Committee views such contact as an indication of vulnerability.

Key to improving outcomes for vulnerable infants is the development of strong and effective working relationships between health and child protection systems. The recommendations arising from Reviews 1 and 2 (see Section 1.1.1) highlight the importance of effective partnerships between these systems.

The Committee made comment on the new Child and Family Health Service (CaFHS) framework for service delivery. The CaFHS has proposed expansion of service provision across five stages of 'healthy development': pregnancy; post-natal; infancy; toddlerhood; and early childhood. 'Healthy development' incorporates physical, language, attachment, social/emotional and cognitive development. The CaFHS considers that effective parenting is the key to improving outcomes for children, and the framework outlines the ways in which parents can be supported, depending on their ability to manage the challenges of parenting, and taking into account the risk and protective factors in their lives.

The Committee considered that the Framework lacked a child-centred focus and that it did not articulate how the benefits to children would be evaluated. The Committee commented about the need for: multiple entry points into the service; less prescriptive service pathways; consultation with children and families; and strengthening partnerships with existing service providers.

The Committee has also continued to pursue improvements to policies and procedures about collaborative case management of 'at risk' infants in birthing hospitals, developed by the Women's and Children's Health Network (WCHN). Committee reviews have shown that birthing hospitals in South Australia have discharged infants into the care of parents where there were major concerns about their capacity to care for the infants. Some of those infants have died – from a deliberate act, neglect, or in unsafe sleeping environments.

There is an opportunity to strengthen and improve the working relationship between birthing hospitals and Families SA, so that informed decisions can be made about the discharge of vulnerable infants. The Committee provided WCHN with a series of questions that would help it to evaluate the effective implementation of the policy and procedures. More recently, the Committee proposed that WCHN hold a forum for all key stakeholders involved in the delivery of services to vulnerable infants and their families, to facilitate understanding of the issues involved in the discharge of these infants. At the time of writing, no response has been received from SA Health about either of these proposals.

1.5. Children with disability

Between 2005-15, twenty-two percent of children who died had lived with a disability.

In 2015-16, the Committee submitted a review to the Minister for Education and Child Development concerning the death of a child with disability.

1.5.1. Review 4 (Case 600)

The major issues arising from this review concerned the delay in the provision of services to a single mother struggling to deal with her child's complex health issues.

When services are contracted out to non-government organisations, there must be a requirement for those services to be delivered in a timely fashion. Funding agencies, such as Disability SA or Families SA, must ensure that the contract is managed, and that the service is delivered as required. It should be remembered that funding

agencies retain responsibility for service recipients. This recommendation is similar to that made in Review 1.

In 2013, the Coroner conducted an inquest into the death of a different young child with disability. The Coroner made recommendations about children with disability who are in the care of the Minister: timely paediatric assessment; exchange of information and case planning that would ensure that a child with disability who is in the Minister's care receives the support and care that they need; and that everyone involved in their care understands and is equipped to provide that level of care.

In 2015, the Committee requested an update from Families SA about the implementation of the Coroner's recommendations.

Families SA provided the Committee with statements about policies for children in alternative care, the Solution-Based Casework model, and the role of placement support workers. Families SA did not provide information about the number of children who had received prompt paediatric assessments, nor the process and timeframe for the provision of a child's medical history to their carers. The Committee has again written to the Minister requesting this information. Again, the Committee expresses its concern that a system that cannot provide such information has no way of knowing whether such children are safe and well.

The National Disability Insurance Agency (NDIA)

The Committee has negotiated the terms of a Memorandum of Understanding (MOU) with the NDIA. The MOU will allow for the release of information to the Committee, about the services provided through the National Disability Insurance Scheme to a child in SA prior to their death.

The Committee continues to hold concerns about the ways in which the NDIS will manage the delivery of services to children with disability, where those children live in vulnerable families. It has recommended that the NDIA must have pro-active and assertive engagement with management of families who actively avoid the NDIS planning process and subsequent services. Specifically NDIA must have active follow-up of families not responding to the letter of offer to meet, and of families who have not spent their assigned service budget.

The Committee's analysis of the deaths of children with disability in the years 2005-15, showed that 11 children were in the care of the Minister when they died. Of those seven were Aboriginal. A review of these deaths will be provided in the 2016-17 Annual Report.

1.6. Infant safe sleeping

More can be done to develop targeted interventions that provide practical support to enable families to provide safe sleeping places for their infant.

The Committee contributed to SA Health's review of the South Australian *Safe Infant Sleeping Standards*. At the time of writing, SA Health had not released the revised document.

Based on its examination of the circumstances of sudden unexpected infant deaths, the Committee remains of the view that:

- Service providers must provide consistent information to families about sleeping their infants safely.
- Particular attention must be given to those families whose lives are relatively chaotic, and where parenting capacity is compromised by such factors as financial constraint, housing insecurity, and alcohol and drug use.
- Innovative solutions must be sought to make it as easy as possible for families to provide safe sleeping arrangements for their infants.

In 2006, the Committee recommended that families who were in need, be provided with cots. This recommendation has never been implemented.

After the earthquake in New Zealand in 2011, public health concerns were raised regarding the anticipated increased likelihood of infants co-sleeping with their parents. These concerns prompted the supply of portable infant sleeping spaces 'pepi pods' for earthquake affected families. Initial evaluation showed that the pods were well received and appropriately used.[7] In relation to the reduction in infant mortality for infants aged 1-52 weeks in New Zealand, Mitchell et al (2016)[8] concluded that: 'It is likely that the components of end-stage prevention strategy, a focus on preventing accidental suffocation, the education 'blitz', the targeted supply of ISSDs and strengthened health policy, have all contributed to varying degrees'. In August 2016,

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[7] *Cowan S, Bennet S, Clarke J, and Pease A (2013), An evaluation of portable sleeping spaces for babies following the Christchurch earthquake of February 2011. J of Paediatrics and Child Health, 49, 364-368.*

[8] *Mitchell E, Cowan S, and Leach D (2016), The recent fall in postperinatal mortality in New Zealand and the safe sleeping programme. Acta Pediatrica – early review. Abstract online at: http://onlinelibrary.wiley.com/doi/10.1111/apa.13494/abstract*

the New Zealand government agreed to fund the distribution of pepi pods in that country.[9]

The Committee supports the introduction of a similar safe sleeping program to target vulnerable families in South Australia.

1.7. Child safety – accident prevention

The Committee has made recommendations about legislative and/or policy changes that support the prevention of death or injury to children in relation to:

Quad bikes – in particular prohibiting the use of quad bikes by children under age 16 years, and prohibiting children of any age as passengers on such vehicles.

The Committee awaits a response from the Attorney-General regarding its recommendations for legislative change.

Child safety in Housing SA properties – following on from the Committee's inquiries about such issues, Kidsafe SA is currently providing advice to Housing SA about child-safe housing issues.

Inflatable swimming pools – the Committee has written to and met with the Commissioner for Consumer Affairs about the regulation of the sale of inflatable swimming pools.

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[9] *http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11686108*

Section Two

Child deaths South Australia 2005-15

S52T – Database

The Committee will maintain a database of child deaths and serious injury cases and their circumstances.

Children's Protection Act 1993

'the power of the child death review process for prevention lies in its ability to provide a systematic source of information on the underlying patterns of circumstances surrounding child deaths'.

Covington T, Wirtz S. cited in Vincent S. Preventing Child Deaths. Learning from Review 2013 Dunedin Academic Press Ltd, Edinburgh.

2. Child deaths South Australia 2005-15

Opportunities for prevention and intervention to improve the safety and wellbeing of children can be identified through the systematic collection and analysis of information about death and serious injury.

2.1. Trends in child death 2005-15

The Committee's analysis is based on the deaths of children up to 18 years of age recorded by the Office of Births, Deaths and Marriages. Deaths after a spontaneous birth of an infant with a gestation of less than 20 weeks, or a termination of pregnancy at any stage of gestation are not included in this analysis.

Trends over time and mapping of child death rates provide useful information when services for children are being planned. Caution interpreting trends over time is advised due to the exclusion of deaths in 2015 not yet registered with the Office of Births, Deaths and Marriages, and several coronial deaths where the cause of death was not known by 30 June 2016.

For the period 2005-2015:

- ***The death rate for all children who died in South Australia showed a 3% decrease on average per year (p=0.005)***
- ***Although the death rate for Aboriginal children has fluctuated over individual years, no trend was found (p=0.8)***
- ***The infant mortality rate has declined by 3% on average per year (p=0.002)***
- ***The rate of sudden unexpected deaths in infancy declined by 7% on average per year (p=0.002)***
- ***Deaths attributed to transport incidents declined by 5% on average per year (p=0.05)***
- ***Deaths of 15 to 17 year olds attributed to transport incidents declined by 11% on average per year (p=0.003).***

Table 4: Trends in child death rates[1], South Australia 2005-15

Year	Number[2]	All	ATSI[3]	FSA[4]	IMR[5]	SUDI[6]	I&D[7]	Trans[8]
2005-2015	**1215**	**31.3**	**105.5**	**8.3**	**3.2**	**0.7**	**20.8**	**3.2**
2005	131	37.9	139.2	8.7	4.4	1.1	24.3	4.3
2006	117	33.8	90.1	8.7	3.3	1.1	19.1	3.2
2007	121	34.7	106.5	8.9	3.9	1.0	22.4	4.6
2008	113	32.3	90.1	7.7	3.2	0.7	22.0	3.1
2009	125	35.6	87.6	9.1	3.4	0.8	23.9	3.4
2010	115	32.6	63.7	8.8	3.5	1.0	21.5	3.7
2011	104	29.5	103.6	9.9	2.8	0.7	21.0	1.7
2012	98	27.6	103.6	7.6	2.7	0.3	19.7	2.5
2013	109	30.5	151.4	7.6	3.2	0.6	21.0	2.0
2014	96	26.7	119.5	6.7	2.7	0.6	18.1	3.1
2015	86	23.9	87.6	7.8	2.4	0.4	15.8	2.5
p value		0.005	0.8	0.4	0.002	0.002	0.05	0.05

1 Rates have been calculated per 100 000 children using ABS population estimates for children between 0-17 years with the exception of the Infant Mortality Rate which is calculated per 1000 live births. See Section 4.16. Caution interpreting trends over time is advised due to the exclusion of deaths in 2015 not yet registered with the Office of Births, Deaths and Marriages, and several coronial deaths where the cause of death was not known by 30th June 2016.
2 Number of children who died in South Australia
3 Aboriginal children
4 Children or their families who had contact with Families SA in the three years prior to their death
5 Infant Mortality Rate – rate per 1000 live births
6 Sudden and unexpected death of an infant - rate per 1000 live births
7 Death attributed to illness or disease
8 Deaths attributed to transport incidents
Source: Child Death and Serious Injury Review Committee database

The death rate for all children who died in South Australia in the eleven years between 2005 and 2015 was 31.3 deaths per 100 000 children.

In 2015, the death rate for Australian children 0-17 years was 39.2 deaths per 100 000 children. [10]

[10] *Australian Bureau of Statistics (2016) Cat No. 3302.0 Deaths, Year of occurrence, Age at death, Age-specific death rates, Sex, States, Territories and Australia http://stat.data.abs.gov.au/Index.aspx?Queryid=457 Accessed October 2016Australian Bureau of Statistics (2012) Australian Demographic Statistics http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3101.0Mar%202014?OpenDocument Accessed October 2016*

Deaths of children and residency in South Australia

In the eleven years between 2005 and 2015, the death rate for children resident in South Australia was 29.4 deaths per 100 000 children. During the same period there were 75 deaths of the children who were not normally resident in South Australia.

Table 5: Deaths of children not normally resident in South Australia

Cultural Background	NSW	NT	QLD	Tas	Vic	WA	Outside Australia
Aboriginal	1	21	2	0	1	2	0
Total	13	36	4	2	11	7	2

Most (57%) of the deaths of Aboriginal children resident in Northern Territory were of infants.

The deaths of many of these children reflect cross-border arrangements whereby seriously ill children are brought to South Australia for high level medical care. Patient transfers from an interstate hospital to a tertiary hospital in South Australia were of women during pregnancy, women and their infant shortly after birth, or infants during an episode of illness in their first year of life. Children and young people with complex medical conditions or with injuries due to various external causes, were transferred to Adelaide for treatment.

Figure 1: Trends in Aboriginal and all child death rates, South Australia 2005-15

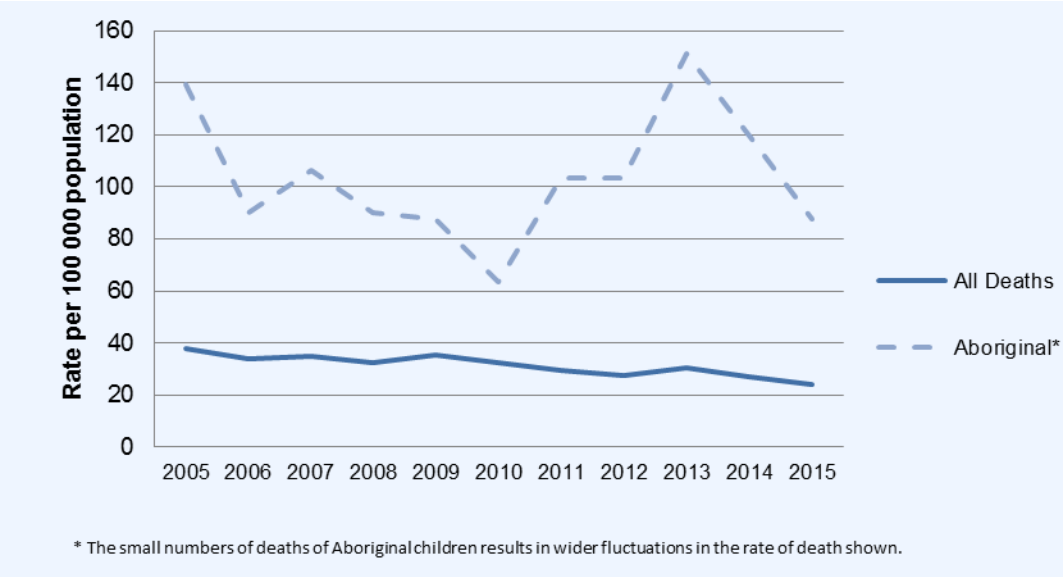


Figure 2: Trends in deaths from transport incidents, illness and disease and all causes, South Australia 2005-15

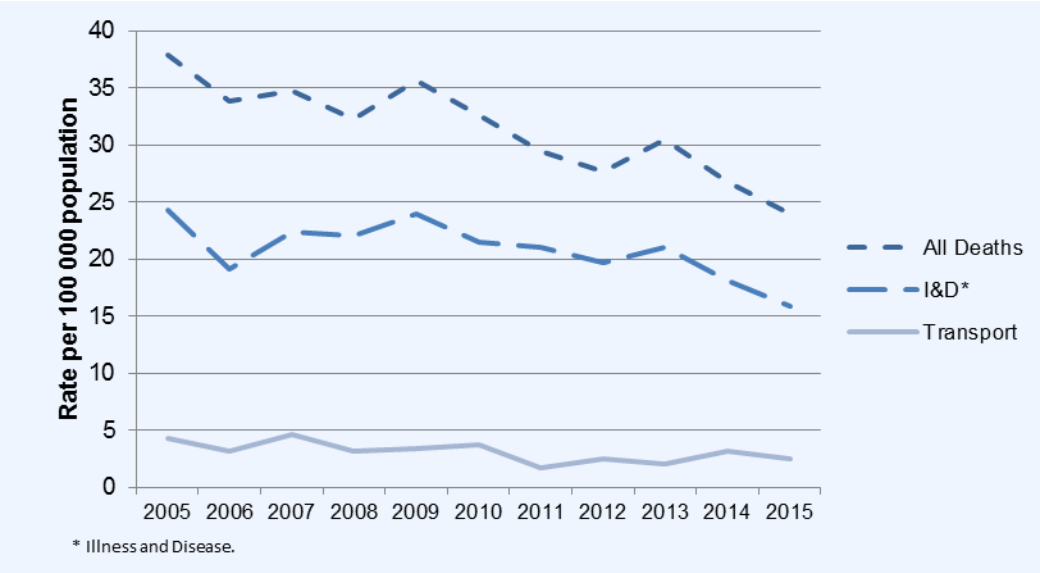
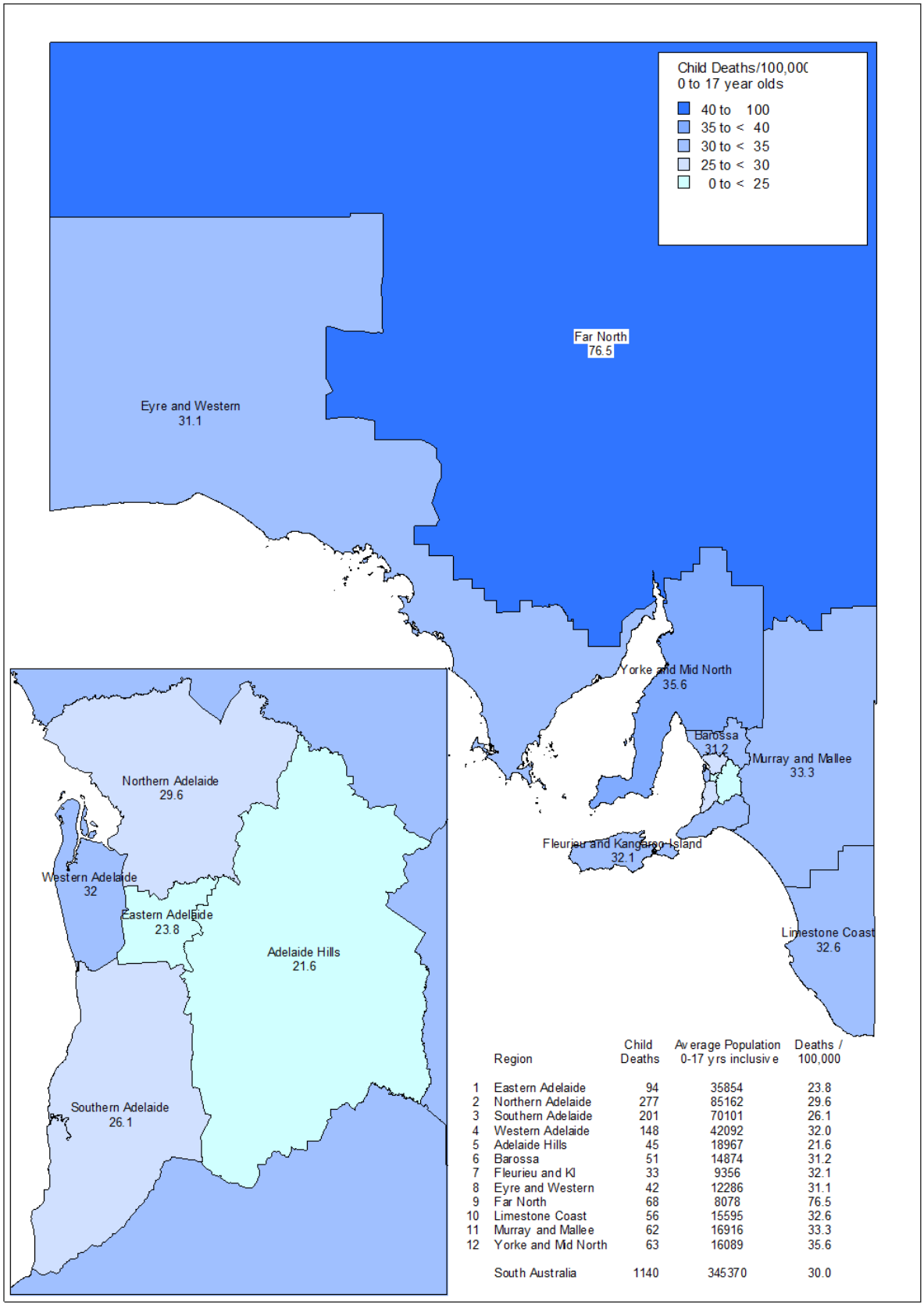


Figure 3: Child death rates by region, South Australia 2005-15



	Region	Child Deaths	Average Population 0-17 yrs inclusive	Deaths / 100,000
1	Eastern Adelaide	94	35854	23.8
2	Northern Adelaide	277	85162	29.6
3	Southern Adelaide	201	70101	26.1
4	Western Adelaide	148	42092	32.0
5	Adelaide Hills	45	18967	21.6
6	Barossa	51	14874	31.2
7	Fleurieu and KI	33	9356	32.1
8	Eyre and Western	42	12286	31.1
9	Far North	68	8078	76.5
10	Limestone Coast	56	15595	32.6
11	Murray and Mallee	62	16916	33.3
12	Yorke and Mid North	63	16089	35.6
	South Australia	1140	345370	30.0

During the period 2005-2015, for all child deaths:

- ***Children younger than one year, and young people 15-17 years had a higher rate of death than those children aged 1-14 years***
- ***Male children had a higher death rate than female children***
- ***Three hundred and twenty-two children who died (27%), or their families, had contact with Families SA in the three years before death***
- ***Children who lived in areas of greatest socioeconomic disadvantage had a higher rate of death than those who lived in areas of least disadvantage***
- ***Living in a remote area was associated with a higher child death rate in comparison to living in a major city area.***

2.2. Groups of children

Children living with disability, in poverty, Aboriginal children, or those who have contact with the child protection system, are more likely to be at risk of poorer health. The deaths of children with those characteristics are considered in more detail in the following sections of the report.

2.2.1. Deaths of Aboriginal children

Table 6: Demographics of Aboriginal child death, South Australia 2005-15

	2005-09	2010–11	2012-13	2014-15	2005-15	Rate[1] per 100 000 2005–15
Total	***63***	**21**	**32**	**26**	**142**	**105.5**
Sex						
Female	*26*	11	14	10	61	90.5
Male	*37*	10	18	16	81	114.6
Age Group						
Infants (<1 year)	*33*	15	19	14	81	10.3[2]
1-4 years	*6*	1	4	3	14	43.7
5-14 years	*9*	3	5	7	24	31.3
15-17 years	*15*	2	4	2	23	104.9
Contact with Families SA[3]						
Families SA	*36*	15	20	17	88	
Usual Residence						
Outside SA	*15*	3	5	4	27	
Socioeconomic Background (SEIFA IRSD)[4]						
Most disadvantaged SEIFA 5	*35*	10	18	21	84	NA[5]
Less disadvantaged SEIFA 1 - 4	*13*	8	9	1	31	NA
Remoteness (ARIA)[4]						
Major City	*19*	10	6	7	42	NA
Regional	*12*	6	18	9	45	NA
Remote and Very Remote	*17*	2	3	6	28	NA

1 Rates for Aboriginal children have been calculated using the Estimated Resident population of Aboriginal children aged younger than 18 years. See Section 4.16.
2 The infant mortality rate is calculated per 1000 live births. See Section 4.16.
3 Death rates for Families SA are not included. See Section 4.16.
4 South Australian residents only included.
5 Not Available
Source: Child Death and Serious Injury Review Committee database

For the period 2005-2015:

- ***Aboriginal children were 3.6 times more likely to die than non-Aboriginal children***
- ***Although the death rate has fluctuated over individual years, no trend was found (p=0.8)***
- ***Although Aboriginal children make up only 3.5% of the population of South Australian children aged 0-17 years, they accounted for 11.6% of the deaths***
- ***Aboriginal children whose family had had contact with Families SA were 11 times more likely to die than non-Aboriginal children***
- ***Seventy-six percent of the deaths of Aboriginal children were of those living in the metropolitan area. Aboriginal children resident in remote and very remote areas were 22 times were more likely to die than non-Aboriginal children from the same areas.***

Table 7: Aboriginal child death by age and cause of death, South Australia 2005-15

Causes of Death	Infants < 1 year	1-9 years	10–17 years	Total	Rate[1] per 100 000 2005-15
Conditions originating in the perinatal period	38	0	0	38	27.8
Transport	1	3	12	16	11.7
Undetermined	13	1	0	14	10.2
Congenital and chromosomal abnormalities	12	2	0	14	10.2
Diseases of the nervous system	0	4	4	8	5.9
Suicide	0	0	7	7	5.1
Accidents	1	3	3	7	5.1
Total	**81**	**22**	**39**	**142**	**103.9**

1 Rates have been calculated using ABS population estimates for children between 0-17 years. See Section 4.16. Thirty-eight deaths of Aboriginal children were due to natural or other causes of death not shown due to low numbers.
Source: Child Death and Serious Injury Review Committee database

During the period 2005-2015 the majority of Aboriginal child deaths were of infants younger than one year. Forty-six percent died from conditions associated with their premature birth.

The second highest death rate was for transport incidents.

2.2.2. Deaths of children with disability

Families caring for children with a disability face significant challenges in accessing services and support for their children. Information on all deaths of South Australian children is reviewed each year by the Committee to determine whether a child's daily activities had been significantly limited due to a disability. Section 4.9 provides further information about the classification of disability and its subtypes.

For the period 2005-2015:

- ***Two hundred and sixty-six (22%) of the 1215 children who died aged 0-17 years had a disability that impacted their daily living***
- ***The death rate for all children with disability shows no change (p=0.6)***
- ***The death rate for children with a disability aged 1 to 4 years has decreased by 7% on average per year (p= 0.1,) and increased by 4% on average in children aged 5 to 14 years (p=0.2)***
- ***Aboriginal children with a disability were 2.5 times more likely to die than non-Aboriginal children with a disability***
- ***Male children with a disability had a higher rate of death than female children with disability***
- ***The death rate for children with disability was higher in areas of socioeconomic disadvantage than in less disadvantaged areas***
- ***Extremely small numbers of children with disability died in remote and very remote areas of the State.***

Table 8: Demographics of deaths of children with disability, South Australia 2005-15

	2005–09	2010–11	2012–13	2014–15	2005–15	Rate[1] per 100 000 2005–15
Total	**127**	**53**	**48**	**38**	**266**	**6.9**
Sex						
Female	62	15	25	17	119	6.3
Male	65	38	23	21	147	7.4
Age Group						
Infants (<1 year)	65	23	28	17	133	61.3[2]
1-4 years	25	8	4	7	44	5.2
5-9 years	14	6	5	6	31	2.9
10-14 years	12	10	6	6	34	3.1
15-17 years	11	6	5	2	24	3.5
Cultural Background						
Aboriginal	10	3	3	6	22	16.1
Contact with Families SA[3]						
Families SA	31	15	8	15	69	
Usual Residence						
Outside SA	9	0	2	1	12	
Socioeconomic Background (SEIFA IRSD)[4]						
Most disadvantaged SEIFA 5	39	18	14	14	85	8.7
SEIFA 4	26	12	8	4	50	5.9
SEIFA 3	22	13	12	8	55	8.2
SEIFA 2	18	5	7	7	37	5.2
Least disadvantaged SEIFA 1	13	5	5	4	27	4.1
Remoteness (ARIA)[4]						
Major City	79	38	35	25	177	6.4
Inner Regional	12	6	3	7	28	6.1
Outer Regional	23	8	6	5	42	8.5
Remote and Very Remote	4	1	2	0	7	4.9

1 Rates have been calculated using ABS population estimates for children between 0-17 years. See Section 4.16.
2 The infant mortality rate is calculated per 100 000 live births. See Section 4.16.
3 Death rates for Families SA are not included. See Section 4.16.
4 South Australian residents only included.
Source: Child Death and Serious Injury Review Committee database

Deaths of children with disability aged 1-17 years old

The Committee has determined the disability types associated with child deaths and disability for children aged 1-17 years, as follows.

Table 9: Deaths of children with disability 1-17 years, disability type and age at death, South Australia 2005-15

Disability type[1]	1-9 years	10–17 years	Total n=133	Rate[2] per 100 000 2005-15
Neurodegenerative disease, genetic disorder and birth defects	49	24	73	2.0
Cerebral palsy	14	22	36	1.0
Epilepsy	16	22	38	1.0
Heart and circulatory problems	11	2	13	0.4
Intellectual disability	4	7	11	0.3
Autism	1	3	4	0.1
Other disability types	6	4	10	0.3

1 Children with multiple disabilities have been included in all relevant disability subtypes
2 Rates have been calculated using ABS population estimates for children between 1-17 years. See Section 4.16.
Source: Child Death and Serious Injury Review Committee database

Figure 4: Deaths of children with disability 1-17 years by disability type and age, South Australia 2005-15

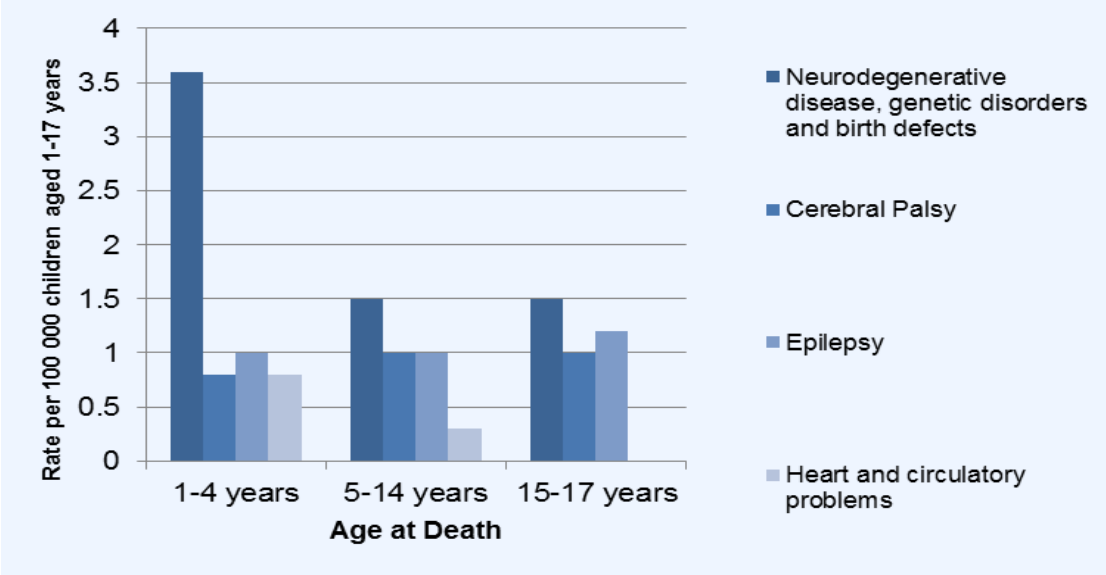


Table 10: Deaths of children with disability 1-17 years by cause of death, South Australia 2005-15

Disability type[1]	I&D[2]	Tr[3]	Delib[4]	Dro[5]	Sui[6]	Undet[7]	Acc[8]	Total[9] n=133
Neurodegenerative disease, genetic disorder and birth defects	65	0	0	2	2	1	1	73
Cerebral palsy	32	0	0	1	0	0	1	36
Epilepsy	33	0	0	2	0	0	1	38
Heart and circulatory problems	13	0	0	0	0	0	0	13
Intellectual disability	5	1	1	0	0	1	3	11
Autism	0	0	0	1	1	1	1	4
Other disability types	7	0	0	1	0	0	0	10

1 Children with multiple disabilities have been included in all relevant disability types
2 Deaths of children aged 1-17 with a disability attributed to illness and disease
3 Deaths of children aged 1-17 with a disability attributed to transport incidents
4 Deaths of children aged 1-17 with a disability attributed to deliberate acts
5 Deaths of children aged 1-17 with a disability attributed to drowning
6 Deaths of children aged 1-17 with a disability attributed to suicide
7 Deaths of children aged 1-17 with a disability attributed to undetermined causes
8 Deaths of children aged 1-17 with a disability attributed to accidents
9 Rates have been calculated using ABS population estimates for children between 0-17 years. See Section 4.16. Four deaths were attributed to health system events
Source: Child Death and Serious Injury Review Committee database

For the period 2005-2015:

- ***Trends in death rates for types of disability varied and no trend reached statistical significance:***
  - ***cerebral palsy – a 7% increase on average per year (p=0.2)***
  - ***epilepsy – a 7% increase (p=0.2)***
  - ***neurodegenerative disease, genetic disorders and birth defects – a 1% decrease (p=0.7).***
- ***Most deaths of children with a disability were attributed to illness and disease.***

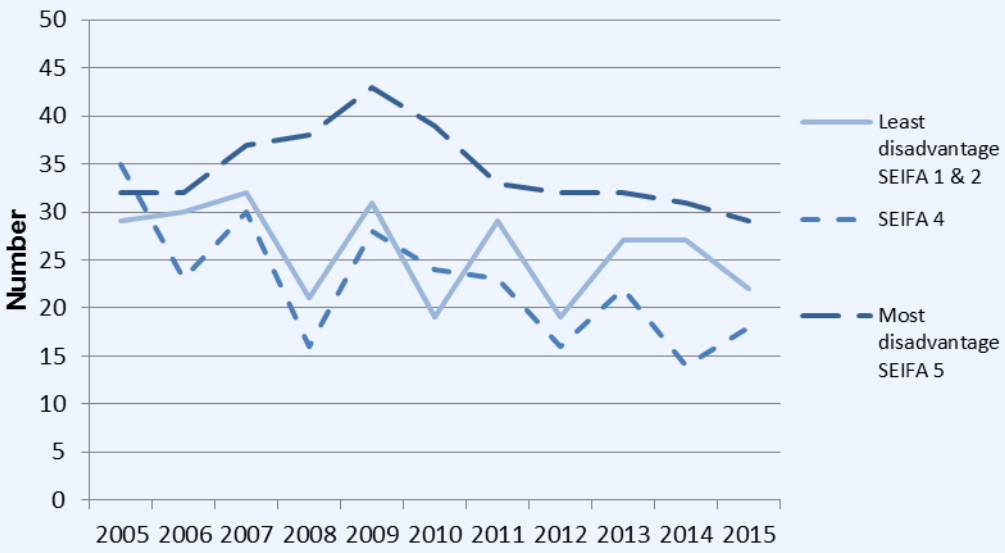
2.2.3. Deaths of children from disadvantaged areas

The connection between child death and disadvantage is very strong. In a recent series of articles about child death review, it was noted that:

> ***'Relative poverty is highlighted as the most important social determinant for child deaths in high-income countries. The authors identify a persistent – across all causes and in time – inverse association between socioeconomic status and child mortality in high-income countries.***[11]

Socio-Economic Indices for Areas (SEIFA) are a measurement that rank areas in Australia according to relative socio-economic advantage and disadvantage. The indexes are based on information from the five-yearly Census.

Figure 5: Child deaths by SEIFA and year of death, South Australia, 2005-15



Children who lived in areas of greatest disadvantage had a higher rate of death than those who lived in areas of least disadvantage.

The death rate for children who lived in areas classified as SEIFA 4 and who died in South Australia, showed a 5% decrease on average per year (p=0.003). However, the death rate for children from the most disadvantaged area (SEIFA 5) fluctuated, showing no trend (p=0.4).

[11] *The Lancet V 384 p830 Child deaths: inequity and inequality in high-income countries.*

2.2.4. Deaths of children in contact with the child protection system

Table 11: Demographics of child death and contact with Families SA, South Australia 2005-15

	2005-09	2010-11	2012-13	2014-15	2005-15	Rate[1] per 100 000 2005–15
Total	**150**	**66**	**54**	**52**	**322**	**8.3**
Sex						
Female	60	25	21	20	126	6.7
Male	90	41	33	32	196	9.9
Age Group						
Infants (<1 year)	69	35	24	19	147	67.7[2]
1-4 years	25	12	11	9	57	6.8
5-9 years	10	6	2	9	27	2.6
10-14 years	19	4	5	8	36	3.3
15-17 years	27	9	12	7	55	8.1
Cultural Background						
Aboriginal	36	15	20	17	88	65.4
Usual Residence						
Outside SA	4	0	2	0	6	
Socioeconomic Background (SEIFA IRSD)[3]						
Most disadvantaged SEIFA 5	71	30	28	32	161	16.5
SEIFA 4	35	15	10	7	67	7.8
SEIFA 3	21	12	7	4	44	6.6
SEIFA 2	10	6	4	6	26	3.7
Least disadvantaged SEIFA 1	9	3	3	3	18	2.7
Remoteness (ARIA)[3]						
Major City	80	43	26	36	185	6.7
Inner Regional	15	5	5	3	28	6.1
Outer Regional	35	16	19	6	76	15.4
Remote and Very Remote	16	2	2	7	27	19.0

1 Rates have been calculated using ABS population estimates for children between 0-17 years. See Section 4.16.
2 The infant mortality rate is calculated per 100 000 live births. See Section 4.16.
3 South Australian residents only included.
Source: Child Death and Serious Injury Review Committee database

Table 12: Child death and contact with Families SA by age and cause of death, South Australia 2005-15

Causes of Death	Infants < 1 year	1-9 years	10–17 years	Total	Rate[1] per 100 000 2005-15
Conditions originating in the perinatal period	50	2	0	52	1.3
Undetermined	38	7	1	46	1.2
Congenital and chromosomal abnormalities	27	7	3	37	1.0
Transport	1	9	25	35	0.9
Accidents	7	7	11	25	0.6
Diseases of the nervous system	2	9	10	21	0.5
Suicide	0	0	20	20	0.5
Cancer	1	12	6	19	0.5
Deliberate Acts	3	8	2	13	0.3
Total	**147**	**84**	**91**	**322**	**8.3**
Disability[2]	**22**	**27**	**20**	**69**	**1.8**

1 Rates have been calculated using ABS population estimates for children between 0-17 years. See Section 4.16. Fifty-two deaths of children whose family had had contact with Families SA were due to natural or other causes of death not shown due to low numbers. The cause of death of two children has not yet been determined.
2 Children who have been determined to have a disability. See Section 4.10.
Source: Child Death and Serious Injury Review Committee database

To be included in this section of the report, the child or a member of their family must have had some form of contact with Families SA within three years of the incident resulting in their death.

Death rates are calculated using the number of children in South Australia, rather than the number of children in contact with Families SA, which is not readily available. This rate only allows for comparison across years (see Section 4.16).

For children or their families who had had contact with Families SA in the period 2005-2015:

- ***Illness or disease accounted for the greatest number of deaths. Over half of these deaths were of infants younger than one year***
- ***Aboriginal children were 11 times more likely to die than non-Aboriginal children***
- ***The majority lived in the State's most disadvantaged areas***
- ***Although the death rate has fluctuated over individual years, no trend was found (p= 0.5)***
- ***Twenty-one percent of children (69 children) were determined to have a disability.***

Table 13: Deaths of children under guardianship, South Australia 2005-15

	2005-15	Rate[1] per 100 000 2005–15
Total	**19**	**0.5**
Sex		
Female	6	0.3
Male	13	0.7
Age Group		
0-4 years	5	0.5
5-14 years	6	0.3
15-17 years	8	1.2
Cultural Background		
Aboriginal	12	8.8
Usual Residence		
Outside SA	1	
Socioeconomic Background (SEIFA IRSD)[2]		
Most disadvantaged SEIFA 4 and 5	12	0.7
Least disadvantaged SEIFA 1, 2 and 3	6	0.3
Remoteness (ARIA)[2]		
Major City	11	0.4
Regional and Remote	7	0.6
Cause of Death		
Transport	3	0.1
Accidents	3	0.1
Other	13	0.3
Disability[3]	11	0.3

1 Rates have been calculated using ABS population estimates for children between 0-17 years. See Section 4.16.
2 South Australian residents only included.
3 Children who have been determined to have a disability. See Section 4.10.
Source: Child Death and Serious Injury Review Committee database

During the period 2005-2015, of children under the Guardianship of the Minister, Aboriginal children, children with disability, and those who lived in the States most disadvantaged areas, made up a significant proportion of these deaths.

Table 14: Deaths of children with a parent who has a history of guardianship, South Australia 2005-15

	2005-15	Rate[1] per 100 000 2005–15
Total	**16**	**0.4**
Sex		
Female	10	0.5
Male	6	0.3
Age Group		
Infants (<1 year)[2]	13	6.0
1-17 years	3	0.1
Cultural Background		
Aboriginal	7	5.1
Usual Residence		
Outside SA	2	
Socioeconomic Background (SEIFA IRSD)[3]		
Most disadvantaged SEIFA 4 and 5	9	0.5
Least disadvantaged SEIFA 1, 2 and 3	5	0.2
Remoteness (ARIA)[3]		
Major City	7	0.3
Regional and Remote	7	0.6
Cause of Death		
Complications of Prematurity	8	0.2
Other	8	0.2

1 Rates have been calculated using ABS population estimates for children between 0-17 years. See Section 4.16.
2 The infant mortality rate is calculated per 100 000 live births. See Section 4.16.
3 South Australian residents only included.
Source: Child Death and Serious Injury Review Committee database

During the period 2005-2015, of the deaths of children whose parent had a history of guardianship:

- ***Half were due to complications of prematurity***
- ***Most (81%) were infants***
- ***Over half (56%) lived in the two most disadvantaged socio-economic areas.***

2.3. Causes of child death

Table 15: Causes of child death by year, South Australia 2005-15

Causes of Death[1]	2005–09	2010–11	2012–13	2014–15	2005-15	Rate[2] per 100 000 2005-15
Certain conditions originating in the perinatal period	161	65	67	50	343	8.8
Congenital malformations, deformations and chromosomal abnormalities	99	27	33	27	186	4.8
Transport	65	19	16	20	120	3.1
Undetermined	43	22	13	14	92	2.4
Cancer	44	13	15	17	89	2.3
Diseases of the nervous system	38	18	9	11	76	2.0
Accident	28	5	9	5	47	1.2
Suicide	15	8	11	5	39	1.0
Deliberate Acts	21	5	3	2	31	0.8
Endocrine, nutritional and metabolic diseases	13	8	4	5	30	0.8
Drowning	16	6	3	2	27	0.7
Diseases of the circulatory system	10	4	7	5	26	0.7
Diseases of the respiratory system	9	7	6	3	25	0.6
Certain infectious and parasitic diseases	11	5	2	3	21	0.5
SIDS	7	2	4	4	17	0.4
Heath-system related	13	0	1	0	14	0.4
Fire-related	5	2	1	1	9	0.2
Neglect	5	0	1	0	6	0.2
Cause not yet known	0	0	0	7	7	
Total	**607**	**219**	**207**	**182**	**1215**	**31.3**

1 Ten deaths were due to causes including diseases of the eye and adnexa, digestive system, musculoskeletal system & connective tissue, genitourinary system or other external causes.
2 Rates have been calculated using ABS population estimates for children between 0-17 years. See Section 4.16.
Source: Child Death and Serious Injury Review Committee database

Table 16: Causes of child death by age group, South Australia 2005-15

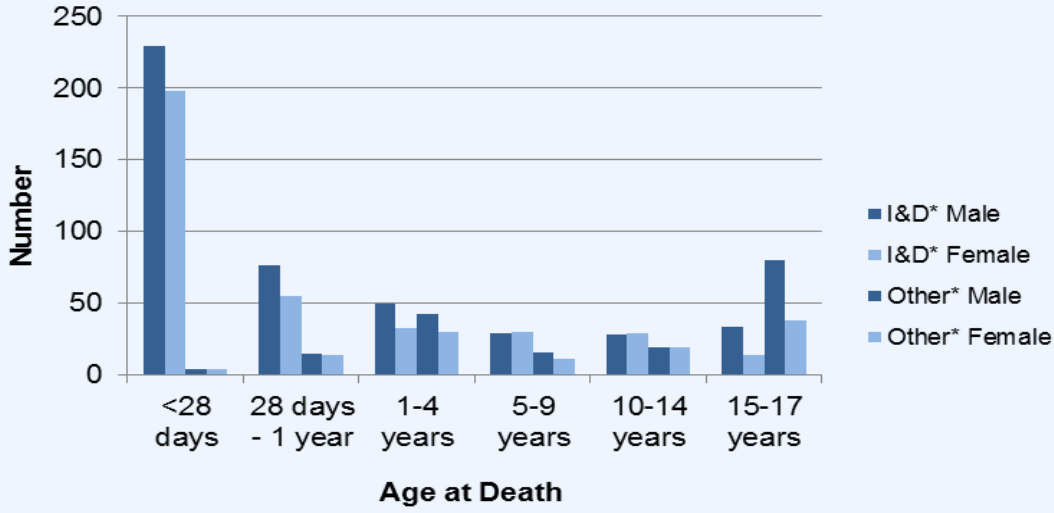
Causes of Death[1]	< 28 days	28 days – 1 year	1-4 years	5-9 years	10-14 years	15–17 years	Total	Rate[2] per 100 000 2005-15
Certain conditions originating in the perinatal period	302	33	4	1	1	2	343	8.8
Congenital malformations, deformations and chromosomal abnormalities	107	42	14	10	7	6	186	4.8
Cancer	2	3	27	25	17	15	89	2.3
Diseases of the nervous system	8	19	16	10	15	8	76	2.0
Endocrine, nutritional and metabolic diseases	4	4	8	4	3	7	30	0.8
Certain infectious and parasitic diseases	3	12	3	0	2	1	21	0.5
Diseases of the circulatory system	1	10	5	4	3	3	26	0.7
Diseases of the respiratory system	0	6	4	5	6	4	25	0.6
Illness and Disease	**427**	**132**	**83**	**59**	**57**	**48**	**806**	**20.8**
Transport	2	3	22	12	19	62	120	3.1
Undetermined	**12**	**65**	**11**	**2**	**0**	**2**	**92**	**2.4**
Accident	2	13	9	6	7	10	47	1.2
Suicide	0	0	0	0	2	37	39	1.0
Deliberate Acts	1	6	15	1	2	6	31	0.8
Drowning	0	3	15	5	2	2	27	0.7
SIDS	**0**	**17**	**0**	**0**	**0**	**0**	**17**	**0.4**
Heath-system related	3	2	4	2	2	1	14	0.4
Fire-related	0	0	6	1	2	0	9	0.2
Neglect	0	2	2	0	2	0	6	0.2
External Causes	**8**	**29**	**73**	**27**	**38**	**118**	**293**	**7.6**
Cause not yet known	0	4	1	1	1	0	7	
Total	**447**	**247**	**168**	**89**	**96**	**168**	**1215**	**31.3**

1 Ten deaths were due to causes including diseases of the eye and adnexa, digestive system, musculoskeletal system & connective tissue, genitourinary system or other external causes.
2 Rates have been calculated using ABS population estimates for children between 0-17 years. See Section 4.16.
Source: Child Death and Serious Injury Review Committee database

For the period 2005-2015, of the 1215 child deaths in South Australia:

- ***The majority (66%) were attributed to illness and disease. Of these, most (43%)were due to conditions originating in the perinatal period and congenital malformation, deformations and chromosomal abnormalities (23%)***
- ***There were 447 deaths in the neonatal period (less than 28 days of life) and 247 deaths in the post-neonatal period (28 days to 1 year of life)***
- ***In the 1-4 year and 5-9 year age groups, cancer was the leading cause of death,[12] followed by transport incidents***
- ***In the 10-14 year age group, transport incidents were the leading cause of death followed closely by deaths from cancer***
- ***In the 15-17 year old group, transport incidents and suicide accounted for 59% of the deaths.***

Figure 6: Death from illness and disease and other causes by age and sex, South Australia 2005-15



[12] *Cancer in South Australia 2013 http://www.sahealth.sa.gov.au/wps/wcm/connect/2ad2eb004d9db4a2bae2bb9f54956e13/2013+SACR+report+v2.pdf?MOD=AJPERES&CACHEID=2ad2eb004d9db4a2bae2bb9f54956e13 Accessed October 2016.*

Figure 7: Other causes of child death by age and cause of death, South Australia 2005-15

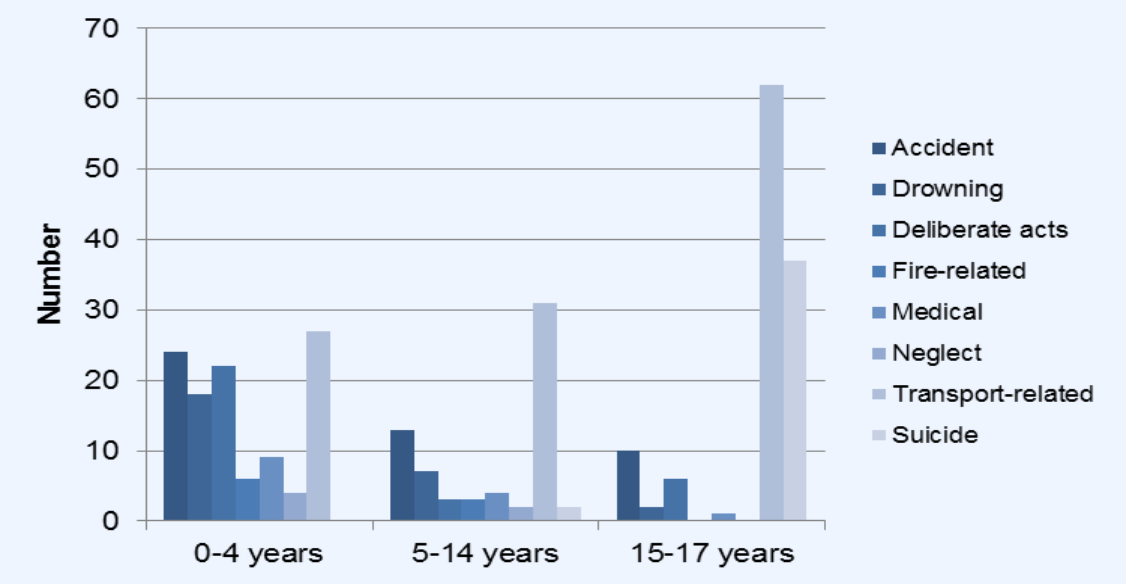
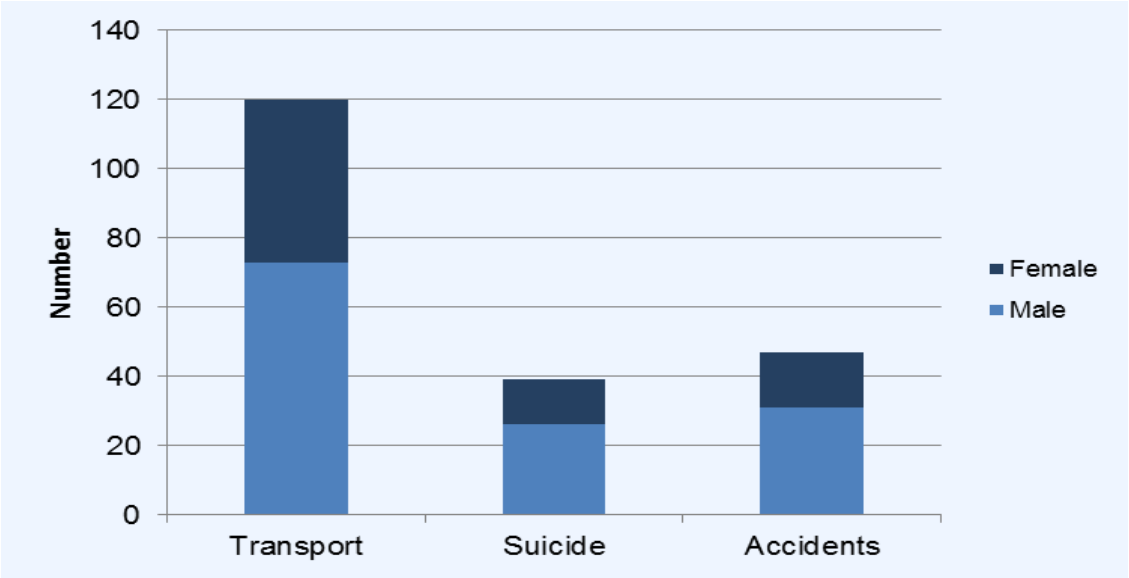


Figure 8: Transport, suicide and accidental death by sex, South Australia 2005-15



2.3.1. Infant mortality

Table 17: Demographics and cause of infant death, South Australia 2005-15

	Age at Death				Total infants	Rate[1] per 1000 2005-15
	< 1 day	1 -6 days	7-27 days	28 days – 1 year		
Sex						
Female	114	48	46	99	307	2.9
Male	135	54	50	148	387	3.5
Cultural Background						
Aboriginal	29	6	7	39	81	10.3
Causes of Death						
Certain conditions originating in the perinatal period	200	60	42	33	335	1.5
Congenital malformations, deformations and chromosomal abnormalities	42	36	29	42	149	0.7
Undetermined Causes	0	2	10	65	77	0.4
Diseases of the nervous system	1	1	6	19	27	0.1
SIDS	0	0	0	17	17	0.08
Certain infectious and parasitic diseases	0	0	3	12	15	0.07
Accidents	0	0	2	13	15	0.07
Diseases of the circulatory system	0	0	1	10	11	0.05
Endocrine, nutritional and metabolic diseases	0	2	2	4	8	0.04
Deliberate acts	1	0	0	6	7	0.03
Diseases of the respiratory system	0	0	0	6	6	0.03
Transport	1	1	0	3	5	0.02
Cancer	2	0	0	3	5	0.02
Drowning	0	0	0	3	3	0.01
Neglect	0	0	0	2	2	0.009
Cause not yet known	0	0	0	4	4	
Total	**249**	**102**	**96**	**247**	**694**	**3.2**

1 Rate per 1000 live births. Rates have been calculated using the number of livebirths from 2005 to 2015 inclusive. See Section 4.16.
2 Eight deaths were due to other causes
Source: Child Death and Serious Injury Review Committee database

Details were obtained from Perinatal Death Certificates for all infants who died before 28 days of age. Further information about causes of death before 28 days of life is available in the infant mortality publications produced by the Pregnancy Outcome Unit of SA Health.[13]

Information about infant mortality in South Australia is recorded in a number of different statistical collections by this Committee, the Australian Bureau of Statistics, and the South Australian Maternal and Perinatal Mortality Committee. Each collection has different ways of registering and recording the deaths of infants, resulting in slight differences in infant mortality rates.

For the period 2005-2015:

- ***The infant mortality rate declined by 3% on average per year (p=0.002)***
- ***Of the deaths of infants from illness or disease, 44% were younger than twenty-four hours***
- ***The most frequent causes of infant death from illness and disease were attributed to conditions originating in the perinatal period, and deaths due to congenital malformation, deformations and chromosomal abnormalities***[14]
- ***Prematurity and its complications were often involved in the deaths of children with conditions originating in the perinatal period and congenital malformations.***

Sudden unexpected deaths of infants

Sudden unexpected death in infancy (SUDI) has been described as an 'umbrella' term that is used for all sudden unexpected deaths of infants younger than one year of age.

Sudden infant death syndrome (SIDS) occurs when infants die during sleep, but where no anatomical, biochemical, microbiological, neuropathological or other indicator of the cause of death could be found at post mortem. (See Section 4.8)

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[13] *Maternal, perinatal and infant mortality in South Australia 2013 http://www.sahealth.sa.gov.au/wps/wcm/connect/90049b804aca21d584bbdc0b65544981/15116.2+Mortality+Report+2013+A5-FINAL.pdf?MOD=AJPERES&CACHEID=90049b804aca21d584bbdc0b65544981 Accessed September 2016.*

[14] *The South Australian Birth Defects Register publishes a comprehensive annual report of the epidemiology of birth defects in South Australia.*

Table 18: Demographics and cause of SUDI deaths, South Australia 2005-15

	2005-15	Rate[1] per 1000 2005-15
Sex		
Female	63	0.6
Male	98	0.9
Age Group		
Deaths in the neonatal period (<28 days)	26	0.1
Deaths in the postneonatal period (28 days to 1 year)	135	0.6
Cultural Background		
Aboriginal	27	3.4
Contact with Families SA[2]		
Families SA	69	
Socioeconomic Background (SEIFA IRSD)[3]		
Most disadvantaged SEIFA 4 and 5	108	
Least disadvantaged SEIFA 1, 2 and 3	52	
Remoteness (ARIA)[3]		
Major City	102	
Regional and Remote	58	
Causes of Death		
Congenital malformations, deformations and chromosomal abnormalities	8	0.04
Certain infectious and parasitic diseases	9	0.04
Diseases of the circulatory system	8	0.04
Other natural causes of death	12	0.06
Undetermined	77	0.4
SIDS	17	0.08
Transport	5	0.02
Deliberate Acts	7	0.03
Drowning	3	0.01
Accidents	15	0.07
Total	**161**	**0.7**

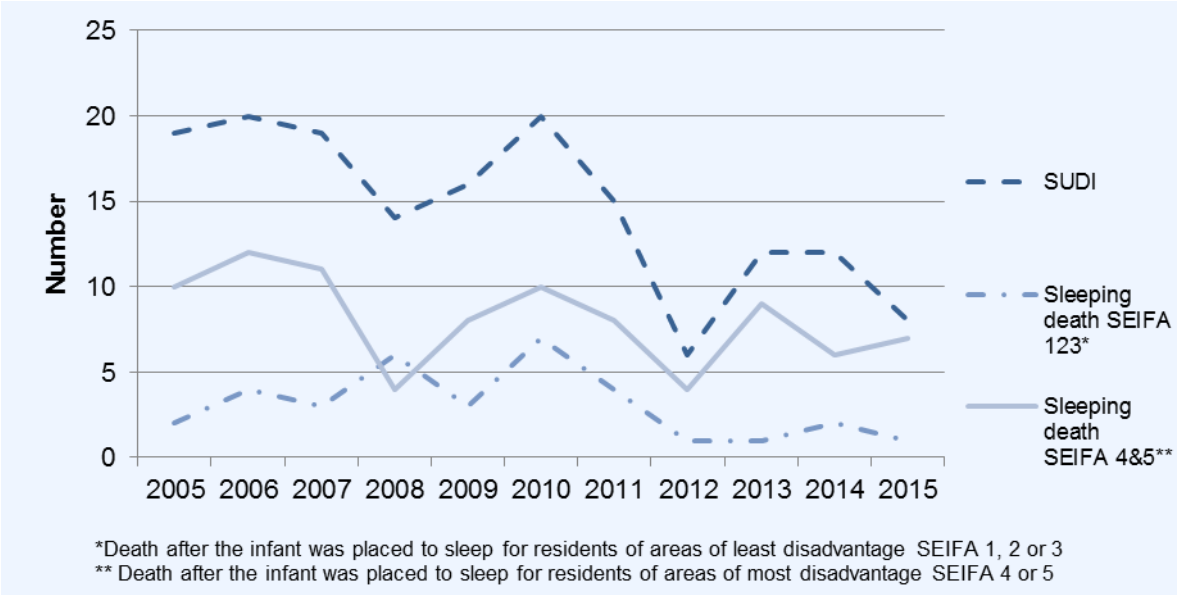
1 Rate per 1000 live births. Rates have been calculated using the number of livebirths from 2005 to 2015 inclusive. See Section 4.16.
2 Death rates for Families SA are not included. See Section 4.16.
3 South Australian residents only. Death rates are not available.
Source: Child Death and Serious Injury Review Committee database

For the period 2005-2015:

- ***The rate of death due to SUDI declined by 7% on average per year (p=0.002)***
- ***Twenty-six deaths were of neonates (less than 28 days) and 135 were post-neonatal deaths***
- ***Two thirds (67%)of these infants lived in the State's most disadvantaged areas (SEIFA 4 and 5)***
- ***Almost half (43%) of these infants or their families, had contact with Families SA in the three years before their deaths.***

Sudden unexpected infant death often occurs when the infant is placed to sleep. At autopsy, the death may be attributed to causes such as illness, disease or suffocation. The majority of these 'sleeping deaths' remain unexplained and will be attributed to an undetermined cause (where no one manner of death is more compelling than other possible causes), or to SIDS (where no explanation for the infant's death can be found).

Figure 9: Death from SUDI by year, South Australia 2005-15



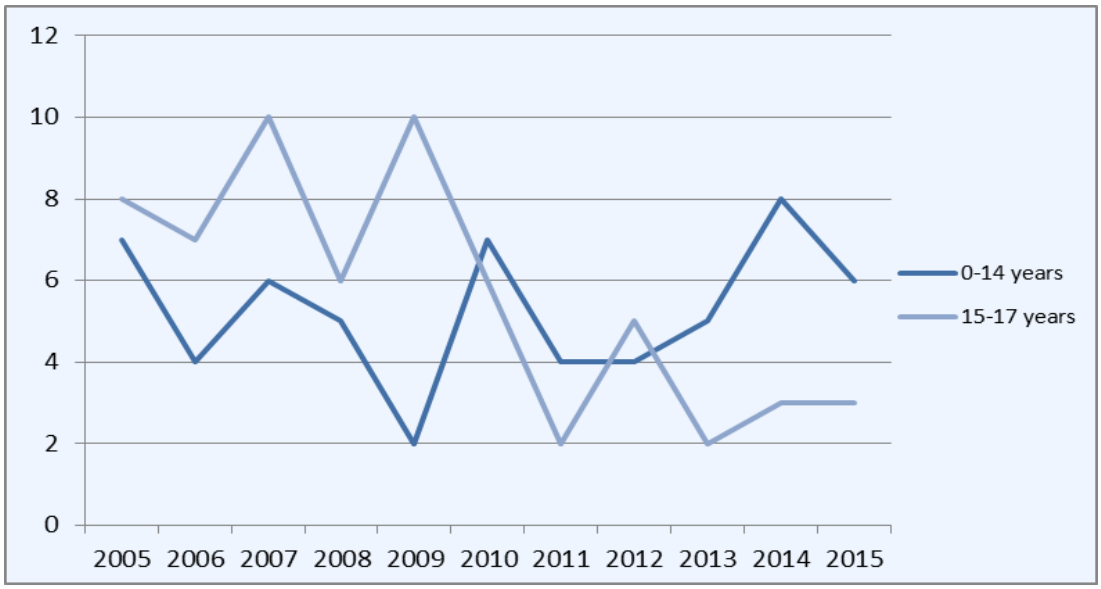
In some, but not all SUDI deaths, risk factors for unsafe sleeping were present. The rate of death for infants who died after they were placed to sleep declined over the period 2005-15 by 5% on average per year (p=0.04). Caution interpreting trends over time is advised due to the exclusion of deaths in 2015 not yet registered with the Office of Births, Deaths and Marriages, and several coronial deaths where the cause of death was not known by 30June 2016.

2.3.2. Transport deaths

For the period 2005-2015:

- One hundred and twenty deaths were attributed to transport incidents
- The rate for all deaths attributed to transport incidents showed a 5% decrease on average per year (p=0.06)
- When only the deaths of 15 to 17 year olds attributed to transport incidents are considered, the death rate showed an 11% decrease on average per year (p=0.003)
- The majority (62%) of children aged 0-14 who died in transport crashes were passengers. Other circumstances of death for this age group were quad bike crashes, pedestrian deaths and low speed driveway rollovers
- Over half of the deaths due to transport incidents were of young people aged 15-17 years. Two-thirds of this group were male.
- Young Aboriginal people were 4.5 times more likely to die due to a transport incident than young non-Aboriginal people.

Figure 10: Transport deaths by age, South Australia 2005-15



2.3.3. Suicide deaths

For the period 2005-2015:

- Thirty-nine deaths were attributed to suicide
- The death rate has fluctuated over individual years, but no trend was found (p = 0.7)

- Thirty-seven deaths attributed to suicide were of young people aged 15-17 years
- Sixty-seven percent of the young people who suicided were male
- The majority lived in metropolitan (23) or inner regional (7) areas of the State.

2.3.4. Accidents

For the period 2005-2015:

- Forty-seven deaths resulted from an accident
- Twenty-seven percent of these deaths were of infants who died suddenly and unexpectedly after being placed to sleep
- Over half of the deaths were of males
- Aboriginal children were 4.8 times more likely to die than non-Aboriginal children due to an accident.
- Over half of these deaths were of children whose family had had contact with Families SA
- Seventy percent of children who died as a result of an accident, were living in areas of greatest disadvantage (SEIFA 4 and 5).

2.3.5. Deliberate acts

For the period 2005-2015:

- Thirty-one deaths were attributed to a deliberate act
- Two-thirds (61%) of the deaths attributed to a deliberate act were of males
- Seventy-one percent of the deaths attributed to a deliberate act were of children 0-4 years old
- Over half (52%) of children aged 0–4 years were killed by a parent.
- Of the 22 deaths of 0-4 year olds, 10 were from injuries associated with a fatal assault, four children died from stab wounds (all perpetrators were fathers), and the remaining eight from various deliberate acts including poisoning, drowning, suffocation and incineration.
- Perpetrators in six deaths of young people 15-17 years were most commonly young, male and known to the victim.`

2.3.6. Drowning

For the period 2005-2015:

- There were 27 deaths by drowning
- Over half (56%) of these deaths were of children aged 1-4 years.

2.3.7. Health system-related adverse events

In the period 2005-2015 the deaths of 14 children were categorised as a health system-related adverse event.

2.4. Further information

Further statistical information can be found on the Child Death and Serious Injury Review Committee's website at http://www.cdsirc.sa.gov.au/pages/publications/.

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Section Three

Committee matters

S52W – Committee's reporting obligations

2) The Committee must, on or before 31 October of each year, report to the Minister on the performance of its statutory functions during the preceding financial year.

Children's Protections Act, 1993

3. Committee matters

3.1. Legislation and purpose

The Child Death and Serious Injury Review Committee was established by the *Children's Protection Act, 1993* in February 2006. It was an initiative arising from recommendations made in *Our best investment: a State plan to protect the interests of children* (Layton, 2003). An interim committee operated under directions issued by Cabinet from April 2005 until February 2006.

The role of the Committee is to contribute to the prevention of death or serious injury to children in South Australia.

The Committee reviews the circumstances and causes of death or serious injury to children, and makes recommendations to Government that may help prevent similar deaths or serious injuries. Recommendations suggest changes to legislation, policies, procedures or practices.

3.2. Committee matters 2015-16

The Committee met eleven times in 2015-16. Each member belongs to one of the four screening teams (see Figure 11) and each of these teams met on additional occasions as required. In-depth reviews were done by ad hoc groups from the Committee, meeting as required to plan and complete each review.

Six members left the Committee in 2016: Alwin Chong, Lynne Cowan, Michelle Hasani, Barry Jennings, Nicole Stasiak and Trish Strachan. Each of them made a significant contribution to the Committee's work.

The Committee continued to work across the following areas:

- The timely and accurate collection of information about the circumstances and causes of child deaths and serious injuries.
- Screening the circumstances and cause of each child death in South Australia, and identifying systemic issues that should be addressed through the review process.

- Undertaking reviews of deaths and serious injuries to identify systemic issues, and making recommendations to the Minister about systemic changes that will contribute to the prevention of similar deaths or serious injuries.
- Monitoring the progress of recommendations, including supporting and contributing to prevention-based activities concerning child deaths and serious injuries.
- Contributing through its Annual Report, to government and community knowledge and understanding of the causes of child deaths and serious injuries, and the efforts that should be made to prevent or reduce deaths or serious injuries.
- Reporting to the Minister on the performance of its statutory functions.
- Maintaining links with interstate and national bodies undertaking similar work.

The Committee's 2015-16 activities are highlighted in Table 19.

3.2.1. The Royal Commission into Child Protection Systems

The Committee made its initial submission to the Royal Commission in 2014-15. The focus of that submission was systemic child protection issues based on the evidence from its reviews, and subsequent recommendations made to the Minister.

In 2015-16, the Committee made two further submissions to the Royal Commission addressing its own powers and functions. The Committee requested that it retain its multi-disciplinary composition, its independence, its powers to keep a database of all child deaths in South Australia, and the ability to review deaths and serious injury.

It requested that legislative change be considered that would:

- Create an imperative for agencies to demonstrate the ways in which implementation of the Committee's recommendations were making a difference to the safety and wellbeing of children.
- Allow the Committee to share details about the circumstances of a child's death with relevant Ministers and agencies.
- Protect this information from further dissemination and publication given its sensitive, personal, and highly identifiable nature.
- Enable the Committee to review individual cases while coronial and criminal processes are proceeding.

- Provide the Committee with a means of obtaining information from Australian government agencies, especially Medibank, Centrelink, and the NDIA.
- Allow the Committee to pass on concerns about the actions of private or public practitioners to a relevant regulatory body such as the Australian Health Practitioners' Regulatory Agency (AHPRA).

The Committee considers the appointment of a Children's Commissioner to be an opportunity to strengthen its own functions by:

- Providing the Commissioner with the power to require response to the Committee's recommendations within required timeframes, including specific data that demonstrates how systemic improvements have been implemented.
- Enabling the Committee to share some details of the circumstances of a child's death with the Commissioner, who could in turn provide some of that information to other agencies.

The Chair of the Committee gave oral evidence to the Commission about these issues.

The Committee also wrote to the Commission about the Coroner's findings in a case of maternal and infant death. The Committee considered that this Inquest provided an example of the difficulties associated with overly restrictive confidentiality requirements, and the need to balance issues of individual privacy and confidentiality with the ability to create an imperative for agencies to implement recommendations that will improve the safety and wellbeing of children.

The Committee also provided information to the Commissioner about the benefits of the Aboriginal Home Birthing Scheme.

3.3. Governance and support

The Committee reports to the Minister for Education and Child Development who has responsibility for the administration of the Act. The Chair has met with the Honorable Susan Close MP on a number of occasions throughout 2015-16.

The Committee's administrative, financial and human resource management is overseen by the Department for Education and Child Development. The Committee was supported by:

Dr Sharyn Watts	Executive Officer
Ms Rosemary Byron-Scott	Senior Project Officer (P/T)
Ms Una Sibly	Senior Project Officer (P/T)
Ms Miranda Furness	Senior Project Officer (P/T until April 2016)
Ms Claire Aberlé	Administration and Information Officer (P/T)

3.4. The ANZCDR&PG

In 2015-16 the responsibility for chairing the Australian and New Zealand Child Death Review and Prevention Group (ANZCDR&PG) passed to the Chair of the Child Death and Serious Injury Review Committee in South Australia, for a term of three years.

This change provided an opportunity to revisit the group's purpose, focus and goals through mechanisms such: as historical analysis of the group's achievements; a member survey about current views; and in-depth workshop style discussion at the 2016 Annual Meeting on 8 April.

The meeting culminated in the group confirming its role as being to identify, address and potentially decrease the numbers of infant, child and youth deaths by sharing information on issues in the review and reporting of child deaths, and working collaboratively towards national and international reporting.

Members further agreed that their three priority focus areas should be:

- Sharing successes and supporting each other
- Elevating issues to the national agenda
- Undertaking comparative analysis in regard to child deaths.

Members also identified the need for both internally focussed solutions (ie, using the meetings as a professional development opportunity for group members) and externally focussed solutions (ie, initiating a website and making reports publicly available), to help achieve their goals within the constraints of increasing resource and budgetary pressures.

ANZCDR & PG significant achievements

The group had a number of significant achievements in 2015-16, including:

- Extending its membership to include the National Children's Commissioner as an auxiliary member of the group
- Raising the profile of the group and the issue of cross-border information sharing through discussion at state and national levels with the Children's Commissioner, and the manager and staff of the Children's Policy Branch of the Families Group in the Australian Government Department of Social Services.

These achievements are particularly important in the context of the group wanting to raise the profile of recommendations and prevention activities.

The Committee will host a two-day meeting of the ANZCDR&PG in April 2017.

The Committee acknowledges with thanks the support of the Minister for Education and Child Development which helps the Committee to host the annual meetings of this group in Adelaide.

Table 19: Highlights of Committee activities 2015-16

	Focus	Activity	Agency	Issues	Response	Monitoring
Neglect and Cumulative Harm	Families SA policies and practices	In-depth review Case 888, recommendations and monitoring	Families SA	Recommendations about training FSA workers, child-centred practice, supervision, case management and monitoring, Adverse Events Committee.	Response received about legislative change.	Monitor the impact of the legislative changes.
	Failures in service delivery	In-depth review Case 1068, recommendations and monitoring	Housing SA SA Health Families SA	Recommendations about discharge of vulnerable newborns, collaboration between Families SA and CAFHS, assessment of parenting capacity, complete family history.	MECD will comment after the Royal Commission in to Child Protection has concluded.	Pursue response from MECD.
	Absence of timely, committed targeted action by various agencies	In-depth review Case 601 and siblings	Families SA Disability Services NDIS	'Suggested actions' about service transitions, case management, assessment of parenting capacity, assessment of risk and safety, the role of disability services and NDIS with vulnerable families.	No response received.	
	Children's Protection Amendments Bill	Submission	Minister for Child Protection Reform	Committee questioned the ability of legislative changes to influence outcomes for children at risk of neglect.	No changes made to the *Bill.*	Through in-depth review monitor the use of the new sections of the Act.
	Responding to recommendations about neglect from 2012 review of six seriously injured children	Correspondence Meeting with senior executives	Housing SA	Housing SA to play a role in sighting children and responding to child protection concerns. Advocating for the role of Housing Officers in assuring the safety of children. Better understanding of changes to culture, policy and practice in Housing SA.	Agency is committed to staff training in child safety and signs of neglect and responding to these issues.	Committee to meet yearly with Housing SA.
		Correspondence Meeting with senior executives	Families SA	Improved assessment and response to neglect and cumulative harm.	Agency consider it is 'better placed' to respond.	Continue to advocate for improvement to assessment and responses.
		Correspondence Meeting with senior executives	Department for Education and Child Development	Improved monitoring of children who are absent from school and chronic truancy and response to chronic truancy.	Agency developing programs and practices that will allow for more timely recognition and response.	Monitor through reviews.
	Cumulative harm	Meeting	Families SA	Recommended pre-emptive checks on children who are the subject of multiple notifications.	No change in practice.	Follow up with the Auditor General.
		Correspondence	Auditor General	Role of the Auditor-General in assessing Families SA's compliance with its statutory obligations.	No response.	
	Assessment of neglect and cumulative harm	Meeting Correspondence	Families SA	Contribute to feedback about the capacity of FSA's 'decision-making' tools to identify and assist with response to neglect and cumulative harm.		Awaiting a final copy of report about changes to decision-making tools.

	Focus	Activity	Agency	Issues	Response	Monitoring
Guardianship	Guardianship and parenting	In-depth group review, recommendations and monitoring	Families SA	Questions to Families SA about reporting on children under guardianship.	Raised with MECD. Discussed with the Guardian for Children and Young People. Response received about policies.	Awaiting further data from FSA.
	Compliance with legislation	Correspondence	Auditor general	Concern expressed about annual reviews of children in care not conducted.	No response received.	
Young people and mental health	Opportunities for prevention and intervention	In-depth group review of deaths attributed to suicide	MECD	Group Review outlining areas for intervention and prevention.	No response received.	Committee will continue to review cases of suicide and promulgate its findings.
	Role of Child and Adolescent Mental health Services	Correspondence	SA Health Chief Psychiatrist Executive Director Mental Health Strategy	Concern expressed about changes to CAMHS and the effect on vulnerable young people.	Meeting with Executive Director Mental Health Strategy is pending.	Seek answers to questions about changes to CAMHS especially for 15-17 year olds.
	Disengagement from services	Correspondence	DECD DCSI	Raising issues about homelessness, chronic truancy and seeking to keep young people engaged in education and housed.	Since 2013, MOUs and guidelines about these issues have been under development by DECD and DCSI.	Continuing questioning these agencies commitment to changes to policy and practice that will support at risk young people.
Vulnerable infants	Transfer of sick infants	Correspondence	SA Health			Committee to monitor outcomes of neonatal retrieval procedure.
	Collaborative Case Management Protocol	Correspondence	SA Health Families SA	Improving processes for discharge of vulnerable infants from birthing hospitals.	Suggested a round table to evaluate first year of operation of the protocol.	Awaiting reply from SA Health.
	Social work support to infant's families	Meeting	SA Health	Improving processes for supporting vulnerable families after discharge.	A meeting with WCHN is pending.	
	Provision of services to vulnerable infants	Submission	CaFHS	Submission about the new CaFHS service framework – calling for a more child-centred approach.	No response received.	Await the revised Framework.

	Focus	Activity	Agency	Issues	Response	Monitoring
Disability	Children in the care of the Minister and disability	Correspondence	MECD Families SA	Requested information about implementation of Coronial recommendations: oversight of medical care in OOHC, care plans, adequate resources.	Response received that only partially addressed questions raised.	Further queries sent.
	Interface between FSA and NGOs	In-depth review of Case 600, recommendations and monitoring	Families SA	Ensuring non-government organisations are suitably qualified and capable of providing care to children with a disability.	Awaiting response.	
	Oversight of quality of service delivery	Correspondence Meetings	NDIS	MOU with NDIS regarding release of information about service provision and children with disability.	Final draft of MOU received.	Awaiting response from NDIS.
	Advocacy	Correspondence	Select Committee on Disability DCSI DECD	Submission about Committee's views of children's experiences Support for Centre for Disability Health remaining open Advocacy for the continuation of the Team Around the Child approach in DECD.		
Child safety	Infant safe sleeping	Liaison, Committee membership	SA Health	Review of SA safe sleeping standards.	Not yet published.	
	Smoke Alarms	Correspondence	Housing SA	Housing SA is alerted to their responsibility for maintenance and replacement of smoke alarms.	New process for alarm replacement.	No requirement for further follow-up.
	Child safety and maintenance inspections	Meeting	Housing SA	Housing SA is alerted to their responsibility ensuring the safety of children through regular maintenance inspections.	Working with Kidsafe to improve safety of houses.	Continue to seek updates.
	Safer road infrastructure	Correspondence	Playford Council Minister for Road Safety	Blackspot funding to support improvements to road safety.	Committee support for a median refuge.	
	Inflatable swimming pools	Correspondence Meeting	Minister for Planning Commissioner for Consumer Affairs	Requesting further work to improve 'point of sale' regulations.	Public awareness campaign to be developed prior to summer 2017.	
	Children as passengers on rural roads	Correspondence	CASR	Best ways in which to improve safety on country roads. Better driver education?	Advice received about improving vehicle safety, lowering speed limits on rural roads; and improving roadside environments.	
	Quad bikes	Correspondence	MECD Attorney General Safework SA	Continuing to raise the issue of driver/passenger safety and to advocate for changes to legislation.		

	Focus	Activity	Agency	Issues	Response	Monitoring
Health Care	Escalation of Care procedures	Correspondence	SA Health		Committee to keep informed about the adoption of a QLD procedure giving carers the ability to escalate care in hospital.	
Nyland Royal Commission	Committee role and functions	Submission Correspondence Oral evidence	Nyland Royal Commission	Submission regarding the roles and functions of the Committee and suggestions about changes to legislation that would enhance/improve Committee's ability to review and monitor child deaths.		Await Nyland Commission recommendations.
National issues	Contributing to the review of child deaths nationally	Chair and secretariat duties	ANZCDR&PG	Between March 2015-18 the Committee will Chair the ANZCDR&PG and host the national meeting of this Group.		

Section Four

Methodology

4. Methodology

4.1. Deaths included in the Annual Report

In Section 2, the number of deaths referred to are based on the calendar year: 1 January 2015 to 31 December 2015. Reporting by calendar year is consistent with the practices of the Australian Bureau of Statistics (ABS) and child death review teams in other states and territories.

The date of death is used as the marker for its inclusion in the data set for that year.

The number of deaths the Committee reports on each year is based on information received from the Office of Births, Deaths and Marriages.

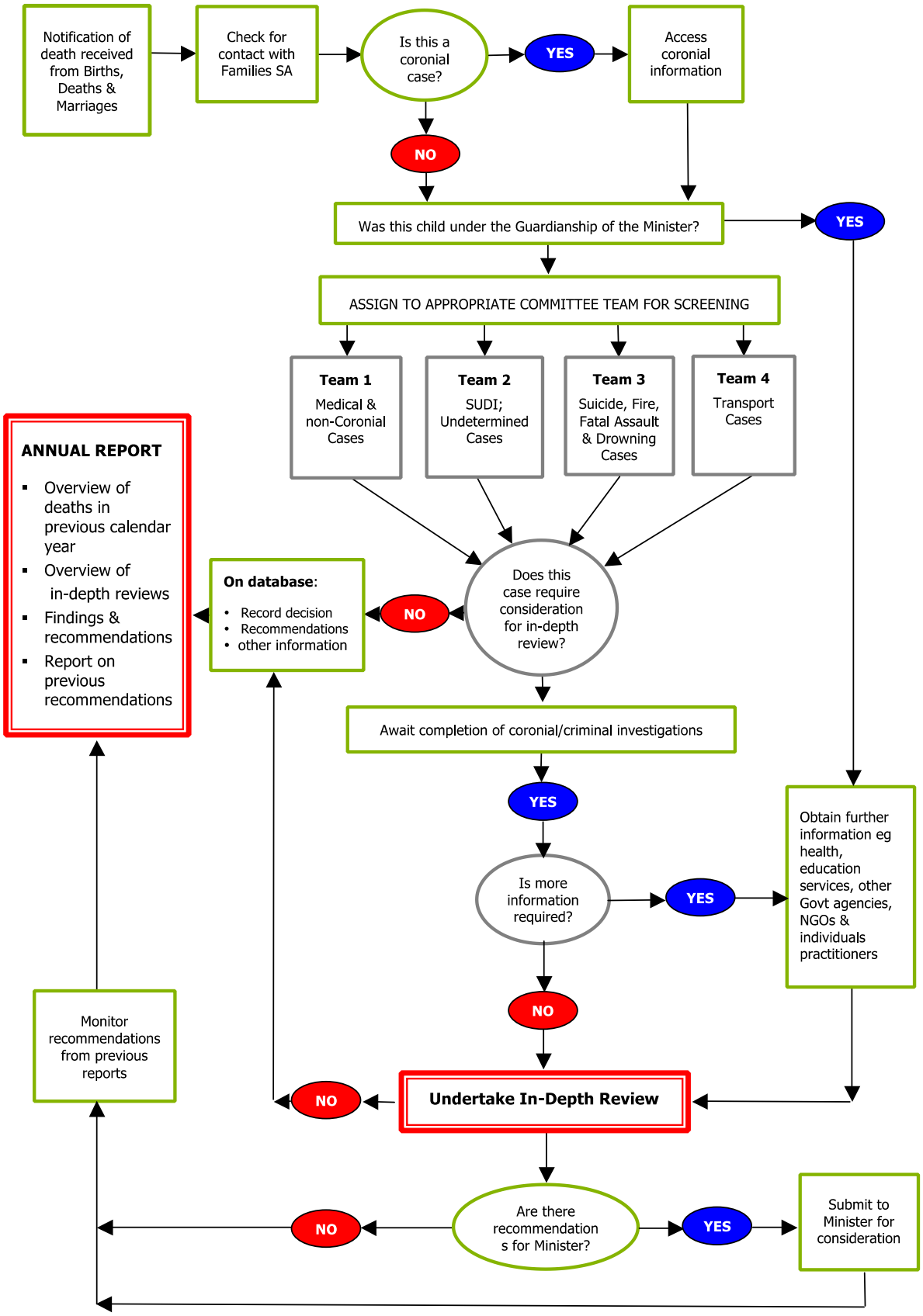
In 2013, the Committee determined that the following deaths would be excluded from the annual report:

- Where the death of an infant occurred after a genetic termination of pregnancy as recorded in the Perinatal Death Certificate; or
- Where the death occurred after the spontaneous birth of an infant prior to 20 weeks gestation.

4.2. Access to information and the process for screening and review of deaths

Figure 11 indicates the key sources of information available to the Committee about the deaths of children in South Australia, and illustrates the processes the Committee uses to screen and review this information.

Figure 11: Committee's Screening and Reviewing Process



4.3. The Office of Births, Deaths and Marriages

The Committee currently has a protocol with the Office of Births, Deaths and Marriages for the release of information about the deaths of children in South Australia. This information is provided to the Committee on a monthly basis.

4.4. The Office of the State Coroner

Under an arrangement with the Coroner, information is released to the Committee for each reportable death of a child aged under 18 years.

A further protocol outlines the exchange of information between the Committee and the Domestic Violence Research Officer attached to the Coroner's Office.

4.5. Release of information from government agencies

The Committee has protocols with SA Health and the Department for Education and Child Development, which includes Families SA, regarding release of information.

A further protocol outlines the exchange of information between the Committee and the SA Health Maternal and Perinatal Mortality Committee.

4.6. In-depth review process

Deaths screened by the Committee are assigned one of the following criteria:

- Not eligible for review - a case will be considered ineligible for review under s52S (2) of the Act – if the child was not normally resident in the State at the time of death or serious injury or the incident resulting in death or serious injury did not occur in the State
- Not for review - a case may not require in-depth review if the screening of information available at the time indicates that there are no systemic issues arising from the death. These cases are assigned a category of death, eg, illness and disease, SUDI, transport, deliberate acts etc, and the details are kept on the Committee's database until required for inclusion in the relevant Annual Report. These cases may be included in reviews in later years where features from cases over a number of years suggest that there may be systemic issues that can be addressed.

- Pending further information - in some cases the Committee requests further information prior to making a decision regarding in-depth review. The majority of cases awaiting further information are deaths attributed to illness and disease or health-system-related adverse events. The medical screening team maintains a high level of scrutiny over the circumstances of the deaths of children from these causes, especially where children have received health services, have had complex conditions requiring a high level of care, or where there has been an interface between medical, welfare and other systems.
- Pending completion of investigations - in accordance with Section 52S (4) of the Act, the Committee must not undertake a review if there is a risk that the review would compromise an ongoing criminal investigation and cannot undertake a review of a coronial matter until that inquiry has been completed. Criminal investigations are considered to be concluded once any person involved in the death or serious injury of the child has been sentenced, or once South Australia Police have determined they have no further interest in the matter. Investigations conducted by the Coroner are considered to have ended when the Coroner has made a finding into the cause of death or a coronial inquest has been completed.
- Awaiting assignment - in any reporting year, there are also cases ready for review but awaiting assignment of a 'review team' to undertake the review.

The number of cases pending investigation or review gradually decreases in any year as information is obtained, cases are finalised in the criminal and coronial systems, and the Committee makes a determination about further review and undertakes this review.

4.7. Reporting requirements

Section 52W of the Act outlines the reporting responsibilities of the Committee. It requires the Committee to report periodically to the Minister for Education and Child Development, and also to provide an annual report on the performance of its statutory functions during the preceding financial year.

The Committee submits a report to the Minister for Education and Child Development at the conclusion of each in-depth review. The report contains the Committee's recommendations about systemic issues that may contribute to the prevention of similar deaths or serious injuries.

4.8. The Committee's classification of cause of death

In Section 2 *Child Deaths South Australia 2005-15,* the Committee's classification of the cause of death and the ICD-10 codes have been used. In many cases, the Committee has multiple sources of information available about children (including health, welfare and education records), and is not limited to the causes of death recorded in post-mortem reports or death certificates. Accordingly, the Committee's classification for a particular death may vary from the ICD-10 classification.

At the time of classifying a death, the Committee will consider all available information. However in some cases, further information may become available that may give rise to a change in the classification assigned to a particular death or group of deaths. Any changes will be noted as an addendum in the subsequent Annual Report. In addition, the Committee will continue to review its definitional guidelines in the light of available information.

Table 20: Committee cause of death classifications

Cause	Committee classification
Transport–related	Transport-related deaths include deaths resulting from incidents involving a device used for, or designed to be used for, moving people or goods from one place to another. These incidents may involve pedestrians and include railway or water transport. Incidents may occur on public roads or places other than a public road.
Accidents	Accidents exclude deaths attributed to transport incidents, fires or drowning. Also referred to as deaths from unintentional injuries, these deaths most commonly include accidental: suffocation, strangulation and choking, falls and poisoning.
Suicide	The Committee's definition of suicide is: *Taking one's own life, intending to do so.* The Committee defines a death as suicide if, after a thorough review of all available evidence, it is satisfied that the young person killed him or herself intending to take their own life. Since adopting this definition, three cases previously attributed to suicide have now been reclassified as accidental deaths, resulting from misadventure.
A deliberate act by another causing death	In previous years one of the categories of death due to external causes was known as 'fatal assault.' A 'fatal assault' was defined as 'the death of a child from acts of violence perpetrated upon him or her by another person'.[15] From time to time cases were included in that category which did not really fit the definition of a fatal assault. For instance, a death caused by the deliberate administration of a drug to a child without any intention of causing the child's death. Accordingly, the Committee considered that a category known as 'a deliberate act by another causing death' better described a range of deaths, including deaths from acts of violence, where a person, by whatever means, causes a child's death by a deliberate act. It is the Committee's view that a simple definition avoids the sorts of complications that would

[15] *Lawrence, R. (2004) Understanding fatal assault of children: a typology and explanatory theory. Children and Youth Services review, 26, 841-856.*

	inevitably arise if one sought to establish the intent of the person whose deliberate act results in a child's death. For instance,in the example of the deliberate administration of a drug to a child, the person's intent could be to medicate the child. Other examples might include hitting a young child to quieten them, but in such a way that death ensued. Of course in more extreme cases, the person's intent might well be to seriously injure or indeed kill the child. While a person's intent is obviously relevant to issues of criminal liability, for the Committee's categorisation of deaths this does not need to be considered. Similarly, there may be cases where the person who causes a child's death does so as a result of mental illness, leading to a Court finding of mental incompetence. Such cases are also included in this category. It will not always be possible, on the basis of the available evidence, to be certain that a child's death resulted from a deliberate act by another person. For instance a child may have serious head injuries causing death, but it is not possible to say that the injuries were deliberately inflicted as opposed to being caused by an accidental fall. In such cases, upon consideration of all the available evidence, the Committee will decide which is the most likely cause of death.
Neglect	The Committee defines neglect as 'a death resulting from an act of omission by the child's carer(s)' including: • Failure to provide for the child's basic needs • Abandonment • Inadequate supervision, and • Refusal or delay in provision of medical care. This definition can account for both chronic neglect and single incidents of neglect, or a combination of both.[16]
Health-system related	These deaths have been classified as such by the Committee based on written records which may not necessarily be complete. The Committee places a death in this category based on consideration of preventable aspects in the circumstances of the death and a focus on future prevention strategies rather than an investigation of the cause of death.
Sudden unexpected infant death	Sudden unexpected death in infancy (SUDI) has been described as an 'umbrella' term that is used for all sudden unexpected deaths of infants younger than one year of age. The definition of Sudden Unexpected Death in Infancy (SUDI) In December 2007 the Australian and New Zealand national meeting of child death review teams and committees agreed to work towards a common reporting framework that was based on the definition of SUDI proposed by Fleming et al. (2000).[17] The agreed SUDI definition is: Infants from birth to 365 completed days of life whose deaths: Criterion 1 Were unexpected and unexplained at autopsy; Criterion 2 Occurred in the course of an acute illness that was not recognised by carers and/or by health professionals as potentially life-threatening; Criterion 3 Arose from a pre-existing condition that had not been previously recognised by health professionals; or Criterion 4 Resulted from any form of accident, trauma or poisoning.
Sudden infant death syndrome	The criteria used to determine a death attributed to SIDS continues to be the San Diego definition proposed by Krous et al. (2004, see Table 21). Death rates for SIDS are reported per 100 000 livebirths.

[16] *Lawrence, R. & Irvine, P. Redefining fatal child neglect. Child Abuse and Prevention, 21, 1-22.*
[17] *Fleming, P., Bacon, C., Blair, B. and Berry, P.J. (2000) Sudden unexpected deaths in infancy, the CESDI studies 1993-1996. London: the Stationary Office.*

Table 21: Definition of sudden infant death syndrome

General Definition of SIDS*

SIDS is defined as the sudden unexpected death of an infant <1 year of age, with onset of the fatal episode apparently occurring during sleep, that remains unexplained after a thorough investigation, including performance of a complete autopsy and review of the circumstances of death and the clinical history.

Category IA SIDS: Classic features of SIDS present and completely documented

Category IA included deaths that meet the requirements of the general definition and also all of the following requirements.

Clinical

- > 21 days and < 9 months of age;
- Normal clinical history including term pregnancy (gestational age > 37 weeks);
- Normal growth and development;
- No similar deaths among siblings, close genetic relatives (uncles, aunts or first degree cousins), or other infants in the custody of the same caregiver).

Circumstances of Death

- Investigations of the various scenes where incidents leading to death might have occurred and determination that they do not provide an explanation for the death;
- Found in a safe sleeping environment, with no evidence of accidental death.

Autopsy

- Absence of potentially fatal pathologic findings. Minor respiratory system inflammatory infiltrates are acceptable; intrathoracic petechial haemorrhage is a supportive but not obligatory or diagnostic finding;
- No evidence of unexplained trauma, abuse, neglect or unintentional injury;
- No evidence of substantial thymic stress effect (thymic weight < 15g and/ or moderate/severe cortical lymphocyte depletion). Occasional 'starry sky' macrophages or minor cortical depletion is acceptable;
- Negative results of toxicologic, microbiologic, radiologic, vitreous chemistry and metabolic screening studies.

Category IB SIDS: Classic features of SIDS present but incompletely documented

Category IB includes infant deaths that met the requirements of the general definition and also meet all of the criteria for category IA except that investigation of the various scenes where incidents leading to death might have occurred was not performed and/ or >1 of the following analyses were not performed: toxicologic, microbiologic, radiologic, vitreous chemistry or metabolic screening studies.

Category II SIDS

Category II includes infants that meet category I except for > 1 of the following.

Clinical

- Age range outside that of category IA or IB (ie 0-21 days or 270 days (9 months) through to first birthday);
- Similar deaths among siblings, close relatives or infants in the custody of the same caregiver that are not considered suspect for infanticide or recognised genetic disorders;
- Neonatal or perinatal conditions (eg those resulting from pre-term birth) that have resolved by the time of death.

Circumstances of Death

- Mechanical asphyxia or suffocation caused by overlaying not determined with certainty.

Autopsy

- Abnormal growth or development not thought to have contributed to death;
- Marked inflammatory changes or abnormalities not sufficient to be unequivocal cause of death.

Unclassified sudden infant death

Includes deaths that do not meet the criteria for category I or II SIDS, but for which alternative diagnoses of natural or unnatural conditions are equivocal, including cases where autopsies were not performed.

Post resuscitation cases

Infants found in extremis who are resuscitated and later die ('temporarily interrupted SIDS') may be included in the aforementioned categories, depending on the fulfilment of relevant criteria.

*Krous, H. F., Beckwith, J. B., Byard, R. W., Rognum, T. O., Bajanowsky, T., Corey T., Gutz, E., Hanzlik, R., Keens, T. G. and Mitchell, E. A. (2004) Sudden infant death syndrome and Unclassified infant deaths: A definitional and diagnostic approach. Paediatrics, 114, 234 – 238.

4.9. Deaths of children with disability 1-17 years old

The definition used to determine inclusion as the death of a child with disability for children 1–17 years old is:

- The child was over one year of age at the time of death
- The child's daily activities were limited because of their disability, illness, disease or health problem, and
- The child's daily activities were adversely affected for a period of six months or more.

Where the length of time during which the child's daily activities were adversely affected was unknown, the case was not included on the Register.

Cases where the child had a chronic health issue (eg, asthma, epilepsy, diabetes) were only included on the Register if other disabilities were present.

Some children had multiple types of disability, for example cerebral palsy and epilepsy. Multiple disability diagnoses were recorded for each child when they were identified.

Table 22: Committee definition of disabilities

Disability	Committee definition
Neurodegenerative diseases, genetic disorders and birth defects	This category included all instances of neurodegenerative diseases, genetic disorders and birth defects, including in-born errors of metabolism where the child's health deteriorates over time. Children with many of these conditions are likely to die as a result of their disease and they require significant care as their condition progresses.
Cerebral palsy	This category included all cases of cerebral palsy, which is a term used to describe a group of non-progressive motor function disorders that arise because of damage to, or dysfunction of, the developing brain. This permanent condition can affect body movement, muscle control, muscle coordination, muscle tone, reflex, posture and balance. It may also cause visual, learning, hearing, speech and intellectual impairments, as well as epilepsy.
Epilepsy	Using the guidelines developed to identify disability, this category only included cases where the frequency and severity of the child's epilepsy would have adversely affected their daily activities for a period of six months or more, or the child with epilepsy had associated disability. Epilepsy is a common disorder that is characterised by recurring seizures or sudden, uncontrolled surges in the normal electrical activity in all, or part, of the brain. While the Epilepsy Centre notes that epilepsy can mostly be controlled by taking medication and restricting daily living activities, epilepsy can be associated with sudden unexpected death.
Heart and circulatory problems	This category included all cases where a condition involving the heart or blood vessels was able to be identified, regardless of whether the condition resulted from an infection or from a birth defect. Children with conditions such as complex congenital heart defects or myocardiopathy are, without life-saving surgery such as a heart transplant, at higher risk of dying as a result of their heart or circulatory problems.

Intellectual disability	This category included all cases where the available information suggested that the child had some form of intellectual disability. It was identified as a specific category because it is a developmental disorder, and people living with such disorders have significantly more difficulty than others in integrating new learning, understanding concepts and solving problems.
Autism spectrum disorder	Autism Spectrum Disorder is a lifelong developmental disability that affects, among other things, the way a child relates to his or her environment and their interactions with other people. Where information was available indicating a diagnosis of ASD had been made, a child was placed in this category.
Other types of disability	This category accommodated all of the remaining disability types in children on the Disability Register. It incorporated cases where the child had conditions such as Epstein-Barr virus, systemic lupus and community acquired pneumonia. It also included cases where the available information was too limited to confidently assign the case to a specified category.
Cancer and 'disabling medical conditions'	Several approaches to the classification of cancers and other health conditions that may adversely affect a child's life for longer than six months have been taken by the Committee. In the 2012 Special Report on the deaths of children with disability, these deaths were included in the Disability Register. In 2013, these deaths were re-classified as 'disabling medical conditions' and no longer included in the Disability Register. The Disability team considered that the issues arising from these deaths were primarily about the medical management of these conditions rather than about issues arising from the disability caused by their impact on the child. These deaths will be reported as deaths from illness or disease.

4.10. Deaths of infants with a disability

There is a unique set of challenges associated with identifying disability in infants. A set of criteria have been developed by the Committee to identify the deaths of infants with a disability. Deaths are excluded from consideration if the underlying cause of death is:

- Prematurity alone
- Prematurity and maternal factors, or infection, haemorrhage, digestive or respiratory problems
- SIDS
- Undetermined or external causes of death
- Cancer
- Heart disease, including myocarditis and cardiomyopathy
- Congenital malformations of major organs such as heart, kidney and liver.

Once these cases are excluded, the ICD-10 underlying cause of death code is cross-referenced against a list of ICD-10 Codes that the Disability Review team[18] has confirmed as representing disability. These codes had previously been identified with

[18] *The Disability Review team comprises three members of the Committee and includes a medical practitioner with in-depth knowledge about children with disability, a child psychologist and a social work consultant.*

reference to the codes used to identify disabilities in the 1-17 year age group. The remaining deaths are then reviewed by the Disability team and a decision made about inclusion in the Disability register based on the available information.

4.11. Aboriginal and Torres Strait Islander Status

The information received from the Office of Births Deaths and Marriages has an Aboriginal or Torres Strait Islander indicator for each case. The Committee has determined that, in the absence of any other form of reliable indicator of ATSI status, this indicator will be used.

4.12. Deaths of children in contact with the child protection system

To be included in this section of the report, the child or a member of their family must have had some form of contact with Families SA within three years of the incident resulting in their death.

The guardianship status of a child or parent is determined during the process of checking each child and their family for contact with Families SA. A child or parent may have been under guardianship in another Australian State.

4.13. Usual place of residence

The information received from the Office of Births Deaths and Marriages indicates the 'last place of residence' of each child. This information is taken to indicate the child's usual place of residence for review and reporting purposes. The Committee acknowledges that this information may have been variously interpreted by the person giving the information, and may not reflect a consistent definition of a person's usual residence.

Each Annual Report records the number of cases where the information from the Office of Births Deaths and Marriages shows that the child's last place of residence was outside South Australia.

4.14. ARIA+ Index of Remoteness and Accessibility

ARIA stands for Accessibility/Remoteness Index of Australia. The ARIA methodology was developed by the Australian Government Department of Health and Aged Care in

1977. Minor changes have been made to this original methodology, resulting in the ARIA+ index of remoteness. This Index is a distance-based measure of remoteness.[19] It defines five categories of remoteness based on road distance to service centres: *major city*, *inner regional, outer regional*, *remote* and *very remote*. The *very remote* category indicates very little accessibility to goods, services and of opportunities for social interaction. ARIA+ Index is an indicator of the degree of geographic remoteness of an area and is a more accurate indicator of disadvantage than subjective labels such as 'rural' or 'country'.

4.15. SEIFA Index of Relative Socio-economic Disadvantage

The SEIFA (Socio-Economic Indexes for Areas) Index of Relative Socio-economic Disadvantage (IRSD)[20] draws on a variety of personal and household characteristics (available from the 2006 Census) to rank household and socioeconomic status. The IRSD is calculated to show the relativity of areas to the Australian average for the particular set of variables which comprise it. This average is set at 1000. Scores below 1000 indicate areas with relatively disadvantaged populations under this measure, and scores above 1000 indicate areas with relatively advantaged populations. In this report SEIFA IRSD scores are divided into five quintiles, with the least disadvantaged populations represented in quintile 1 and the most disadvantaged in quintile 5. The SEIFA IRSD score and quintile assigned to a child's residential postcode was obtained from the Australian Bureau of Statistics reports 'Census of Population and Housing: Socio-Economic Indexes for Areas, Australia 2011[21] and 'Census of Population and Housing: Socio-Economic Indexes for Areas, Australia 2006'.[22] For the death years 2005-2008 in this Report the 2006 Census estimate is used, and for 2009-12 the 2011 Census is used.

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[19] *AIHW (2004)* Rural, regional and remote health: a guide to remoteness classifications. *AIHW Cat no PHE 53, Canberra: AIHW http://aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442459567 Accessed September 2014.*
[20] *ABS* SEIFA Indexes *2011 http://www.abs.gov.au/ausstats/abs@.nsf/mf/2033.0.55.001*. Accessed September 2014.
[21] *Australian Bureau of Statistics 2014, Census of Population and Housing: Socio-Economic Indexes for Areas, Australia, 2011, datacube: cat. no.2033.0.55.001, Accessed 3 October 2016, http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/2033.0.55.001Explanatory%20Notes12011?OpenDocument*
[22] *Australian Bureau of Statistics 2008, Census of Population and Housing: Socio-Economic Indexes for Areas, Australia, 2006, datacube: cat. no.2033.0.55.001, Accessed 3 October 2016, http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/2033.0.55.0012006?OpenDocument*

4.16. Death rates

Death rates have been calculated using Australian Bureau of Statistics (ABS) population projections. In the period 2005 to 2015, the estimated number of resident South Australian children aged 0-17 years was 3 879 114.[23] Children who died in South Australia, but whose usual residence was outside of the State, are included in all calculations except the death rates of only those children resident in the State at the time of death.

The death rates for Aboriginal children were calculated using the Estimated Resident population of South Australian Aboriginal children aged younger than 18 years. (12 552 Aboriginal children – 2011 Census).[24]

The Infant Mortality Rate (IMR) is calculated according to the deaths of children younger than one year old per 1000 live births in the same year. For the purpose of comparison in the tables in this report, the IMR is represented as the deaths of children younger than one year old per 100 000 live births in that year. The South Australian Maternal, Perinatal Mortality Committee provided data about live births. Between 2005 and 2015, there were 217 095 live births in South Australia (provided as provisional data on 21 September 2016).

The rates of death for children whose families have had contact with Families SA are calculated by dividing the number of children who died, whose families had contact with Families SA, by the total population of children in SA. The Committee defines 'contact with Families SA' to be any recorded contact in the three years prior to the child's death. It would be preferable to use the denominator 'all children whose family had had contact with Families SA' to calculate the death rate as this would enable a comparison of the rate of death for children whose family had had contact with Families SA and those who had not. However, this information regarding the number of children who had contact with Families SA from 2005-15, is not readily available. A prevalence rate only is presented in this report for the purposes of comparison over time, of the death rates of children whose families have been in contact with Families SA.

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[23] *Australian Bureau of Statistics (2012)* Australian Demographic Statistics *http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3101.0Mar%202014?OpenDocument Accessed September 2016*

[24] *Australian Bureau of Statistics. Table Builder, Accessed October 2016, https://www.censusdata.abs.gov.au/webapi/jsf/tableView/customiseTable.xhtml*

Death rates within SEIFA quintiles are calculated using the total number of children aged 0-17 years in each SEIFA quintile. This information is provided by the ABS.[25]

Death rates within the Accessibility/Remoteness Index of Australia (ARIA) categories are calculated using the total number of children aged 0-17 years in each ARIA category. This information is provided by the ABS.[21]

The Poisson distribution is used to investigate whether there are trends in the number of deaths due to various causes. The Poisson distribution describes the occurrence of rare events. A p-value of less than 0.05 denotes a significant increasing or decreasing trend.

Caution interpreting trends over time is advised due to the exclusion of deaths in 2015 not yet registered with the Office of Births, Deaths and Marriages, and several coronial deaths where the cause of death was not known by 30th June 2016.

4.17. Mapping

South Australian government departments and agencies have developed a consistent set of boundaries to define twelve administrative regions in the State. The relevant government region is assigned to each child's residential postcode.[26] Rates in each region are calculated using the following formula: the sum of child deaths in each postcode within a region, divided by the sum of the total population of children in the postcodes within each region. This information is used to generate maps of the distribution of child deaths within the State.

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[25] *Personal Communication 18 September 2015, Regional Population Unit, Demography, Australian Bureau of Statistics*

[26] *https://www.sa.gov.au/topics/housing-property-and-land/building-and-development/land-supply-and-planning-system/south-australian-government-regions Accessed 10 October 2016*